Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.400 Letter of Intent Process. The committee is amending sections (3), (4) and (5), subsection (6)(E)2, and removing section (8).

PURPOSE: The committee is amending this rule to restructure wording for LTC bed expansion and replacement application requirements, change the word patient to resident, and to include certain CON forms within the rule rather than incorporating them by reference.

(3) [*A LTC bed expansion or replacement sought pursuant to sections 197.318.4 through 197.318.6, RSMo, requires a CON application if the capital expenditure for such bed expansion or replacement exceeds six hundred thousand dollars ($600,000) but allows for shortened information requirements and review time frames.]* **A LTC bed expansion in accordance with section 197.318.4(1)-(3) requires an expedited CON application regardless of the amount of capital expenditure. A LTC bed replacement in accordance with section 197.318.4-6 requires an expedited CON application if the capital expenditure for such bed replacement exceeds six hundred thousand dollars ($600,000).**

(4) When an LOI for a LTC bed expansion is filed, the Certificate of Need Program (CONP) staff shall immediately review that facility's average licensed bed occupancy for the most recent six (6) consecutive calendar quarters, and request certification that the facility had no [*patient*] **resident** care Class I deficiencies within the last eighteen (18) months from the Division of Regulation and Licensure (DRL), Department of Health and Senior Services, through a LTC Facility Expansion Certification (Form MO 580-2351[, *incorporated by reference*]), **included herein,** to verify compliance with occupancy and deficiency requirements pursuant to section 197.318.4(1), RSMo. Occupancy data shall be taken from the CON's most recent Six-Quarter Occupancy of Intermediate Care and Skilled Nursing Facility (or Residential Care and Assisted Living Facility) Licensed Beds report published on the CON website.

(5) For a LTC bed expansion, the sellers and purchasers shall be defined as the owner(s) and operator(s) of the respective facilities, which includes building, land, and license. On the Purchase Agreement (Form MO 580-2352), **included herein,** both the owner(s) and operator(s) of the purchasing and selling facilities shall sign.

(6) The CONP staff, as an agent of the Missouri Health Facilities Review Committee (committee), will review LOIs according to the following provisions:

(E) A Non-Applicability CON letter will be valid subject to the following conditions:

2. Final project costs with third-party verification must be provided on a Periodic Progress Report (Form MO 580-1871)**, included herein**; and

[(*8) The following forms cited in this rule are incorporated by reference and published by the Certificate of Need Program (CONP), May 1, 2012, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a written request to CONP@health.mo.gov, or acquired in person at the CONP Office, 3418 Knipp Drive, Suite F, Jefferson City, Missouri 65102, (573) 751-6403. This rule does not include any later amendments or additions.*

(A) LTC Facility Expansion Certification (Form MO 580-2351).

(B) Purchase Agreement (Form MO 580-2352).
(C) Periodic Progress Report (Form MO 580-1871).]

AUTHORITY: section 197.320, RSMo 2016.* Original rule filed June 2, 1994, effective Nov. 30, 1994. Emergency amendment filed Nov. 16, 1995, effective Nov. 26, 1995, expired May 23, 1996. Amended: Filed Nov. 15, 1995, effective April 30, 1996. Emergency amendment filed Nov. 26, 1996, effective Dec. 6, 1996, expired June 3, 1997. Emergency rescission filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, terminated Sept. 21, 1997. Emergency rule filed Sept. 11, 1997, effective Sept. 21, 1997, expired March 19, 1998. Rescinded and readopted: Filed Aug. 29, 1997, effective March 30, 1998. Emergency rescission and rule filed June 29, 1999, effective July 9, 1999, expired Jan. 5, 2000. Rescinded and readopted: Filed June 29, 1999, effective Jan. 30, 2000. Emergency rescission and rule filed Dec. 14, 2001, effective Jan. 1, 2002, expired June 29, 2002. Emergency amendment filed Dec. 16, 2002, effective Jan. 1, 2003, expired June 29, 2003. Rescinded and readopted: Filed Dec. 14, 2001, effective June 30, 2002. Amended: Filed April 12, 2004, effective Nov. 30, 2004. Emergency amendment filed Aug. 14, 2006, effective Aug. 28, 2006, expired Feb. 23, 2007. Amended: Filed Aug. 14, 2006, effective March 30, 2007. Amended: Filed Oct. 1, 2010, effective May 30, 2011. Amended: Filed Aug. 9, 2019, effective March 30, 2020.
*Original authority: 197.320, RSMo 1979, amended 1993, 1995, 1999.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via e-mail at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Certificate of Need Program

PERIODIC PROGRESS REPORT

Instructions for Completion (see attached blank forms)

Purpose: To gather uniform data regarding the progress and compliance of approved Certificate of Need (CON) projects in accordance with §197.300 to §197.366 RSMo; and to provide data to develop, implement and manage a database for project tracking, monitoring, notification and follow-up.

Used by: Missouri Health Facilities Review Committee, CON Program Staff, and Project Contact Person.

General: Periodic Progress Reports (PPRs) must provide all requested data and information in a complete, concise and legible manner. Each PPR must indicate if it is an Intermediate or Final Report. PPRs which are incomplete, illegible and/or contain mathematical discrepancies may be returned to the Contact Person for appropriate corrective action.

Project ID: Any changes in this information must be brought to the attention of the CON Program Staff immediately upon occurrence.

Add'l. Info.: *Additional information MUST be attached to* ***substantiate*** *answers to the individual questions. All final PPRs must include documentation which substantiates all claims and expenditures.*

Individual Questions:

1. **Have capital expenditures been incurred for the proposed construction and/or medical equipment?** A capital expenditure shall be deemed to have occurred if the applicant has at least one or more of the following:

   - **Construction expenditures** assignable to a capital asset in accordance with generally accepted accounting principles and which are not chargeble to pre-development or operating costs, which may be documented by a signed AIA construction contract with starting and ending dates; and above-ground construction;
   - **Purchase Orders (POs)** which are signed and which include the date of purchase, delivery, installation and operational date; or
   - **Acquisition** of medical equipment or property by lease, transfer, or purchase which has been authorized by the applicant and includes the date of the lease, the annual cost, cost and date of buy-out; purchase date, delivery installation and operational dates; and transfer date, current value, installation and operational date.

   If the answer to this question is "Yes," then attach copies of the appropriate signed construction contract (include pictures of construction activity), purchase order, or lease agreement (with original signatures).

   If capital expenditure or expenditure for medical equipment has not been incurred, provide a detailed explanation and include the steps being taken to correct the situation within the time constraints of §197.315.9 RSMo. Indicate the nature, costs and the date that a capital expenditure will be incurred.

2. **Are the expenditures for this reporting period/project-to-date included?**

   List all project expenditures, by category, incurred during the reported period and project-to-date on the **Project Budget/Expenditures** form.

3. **Are the projected final costs within the limits approved?** *(Self-explanatory)*

   Using current costs and expenditures, extrapolate final project costs to the project completion date. If total costs will exceed those approved by the Committee by more than 10%, specify and explain the area and category involved. Also, indicate the estimated filing date for your cost-overrun application.

4. **Are there any changes in the services or programs as approved in the application?** *(Explain any changes)*

5. **Has the project contact person changed?**
   If "Yes," enclose a new CON Contact Person Correction Form.

6. **Percentage of Construction or installation complete.**

   (If the expenditures and construction/installation are both 100% complete, provide a final report.)

Certificate of Need Program

PERIODIC PROGRESS REPORT

Type of Progress Report:
- ☐ Intermediate
- ☐ Final

All applicants granted a Certificate of Need (CON) by the Missouri Health Facilities Review Committee are required to submit periodic progress reports until such time as the project is complete (§197.315 (8) RSMo). These reports **must** be filed with the CON Program staff after the end of **each six (6) month reporting period** following the issuance of a CON.

Name of Project	Report Period
	Project Number
Address	
	Date CON Issued
Project Description	
	Approved Cost

☐ Yes
☐ No **1. Have capital expenditures been incurred for the proposed construction through aboveground construction, renovations or lease/purchase of the proposed equipment?**

_____ Date aboveground construction or renovations commenced, or equipment purchased. Provide documentation (i.e. photos, copy of AIA contract and/or purchase order).

☐ Yes
☐ No ***2. Are the expenditures for this reporting period/project to-date included?**

_____% Percent of the total approved project amount that has been expended to date.

☐ Yes
☐ No **3. Are the projected final costs within the limits approved?**

If "No" and costs are above 10% of approved amount, then submit a cost over-run application.

$_____Estimated final project cost

☐ Yes
☐ No **4. Are there any changes in the services or programs as approved in the application?**

If "Yes" explain in detail and provide replacement pages for the approved application.

☐ Yes
☐ No **5. Has the project contact person changed?**

If "Yes," enclose a new Contact Person Correction Form (MO 580-1870).

***6. Construction or installation is _____% complete.** *(Not the same as expenditures to-date.)*

If Items 2 and 6 are both 100% complete, signify this as the **Final Report and submit documentation of final costs.*

Describe the status and progress of the project to-date. Clearly explain expenditures, delays, changes in project progress, or lack of progress. *(Use additional pages as needed.)*

Certificate of Need Program

PERIODIC PROGRESS REPORT

Project Budget/Expenditures	Report Period:_____to _____		
Description	**Application**	**This Period**	**Project to-date**
1. General Construction Costs	0	0	0
2. Renovation Costs	0	0	0
3. Subtotal Construction Costs	**$0**	**$0**	**$0**
4. Architectural/Engineering Fees	0	0	0
5. Other Equipment (not in construction contract)	0	0	0
6. Major Medical Equipment	0	0	0
7. Land Acquisition Costs	0	0	0
8. Consultants' Fees/Legal Fees	0	0	0
9. Interest During Construction	0	0	0
10. Other Costs	0	0	0
11. Subtotal Non-construction Costs	**$0**	**$0**	**$0**
12. TOTAL Project Development Costs	**$0**	**$0**	**$0**
Square footage of New Construction	0	0	0
Square footage of Renovation	0	0	0
Total square footage for Project	0	0	0
Costs per square foot: New Construction	0	0	0
Costs per square foot: Renovation	0	0	0

Name of Contact Person	Title

Telephone Number	Fax Number	E-mail Address

LTC Facility Expansion
CERTIFICATION by the Division of Regulation and Licensure (DRL)

Part I: Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____

Number and Type of Beds: _____ ☐ RCF/ALF ☐ ICF/SNF *(check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility)*

Owner(s): _____

Operator(s): _____

Project Number: _____

Part II: Quarterly RCF/ALF/ICF/SNF Bed Occupancy Rate

Occupancy statistics for this facility for the most recent six consecutive calendar quarters prior to the LOI date shown above:
(circle appropriate quarter, insert the Calendar Year (CY), and complete information below)

Qtr 1 2 3 4 CY____: ____% **Qtr 1 2 3 4 CY____:** ____% **Qtr 1 2 3 4 CY____:** ____%

Qtr 1 2 3 4 CY____: ____% **Qtr 1 2 3 4 CY____:** ____% **Qtr 1 2 3 4 CY____:** ____%

Six-quarter average:_____ %

☐ Yes ☐ No For expansion through the **purchase** of beds, based on the DRL Quarterly Survey Data, the 90% bed occupancy requirement has been met.

☐ Yes ☐ No For expansion through the **addition** of beds, based on the DRL's Quarterly Survey Data, the 92% bed occupancy requirement has been met for under 40 LTC beds, or 93% for 40 bed or more LTC beds (see above).

Part III: Deficiencies

■ Yes ☐ No For expansion through the **purchase** or **addition** of beds, based on the DRL's annual facility survey, the above-named facility has not had any final Class I patient care deficiencies during the past 18 months.

Part IV: Certification of Information

Statement: The above information is an accurate representation of the findings by the DRL in accordance with appropriate CON rules.

Signature: _____

Title/Date: _____ _____

Certificate of Need Program

PURCHASE AGREEMENT

Part 1: Purchasing Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____

Number/Type of Licensed Beds: _____ ☐ RCF/ALF ☐ ICF/SNF (Check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility.)

Owner(s): _____

Operator(s): _____

Part II: Selling Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____ _____ _____ _____

Number/Type Licensed Beds: _____ ☐ RCF/ALF ☐ ICF/SNF (Check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility.)

Owner(s): _____

Operator(s): _____

Part III: Value of Consideration

Monetary Value of Purchase: $_____ No./Type Beds:_____

Terms of Purchase: _____

(Add more pages as necessary to describe the sale.)

Part IV: Certification of Information

☐ Yes ☐ No The above Purchaser and Seller have agreed to these purchase terms.

Purchaser Signature: _____

Title/Date: _____ _____

Seller(s) Signature(s):

Owner(s):_____

Operator(s):_____

Title/Date: _____ _____