19 CSR 60-50.430 Application Package. The committee is amending sections (6), (7), and (8), paragraphs (2)(C)4 and (2)(B)1-7, subsection (3)(A), (3)(B), (3)(C) and (4)(C), paragraphs (4)(C)1 and 4(C)2, subparagraph (4)(C)2.D, adding new section (7) and subsection (4)(D), deleting section (8) and renumbering as needed.

PURPOSE: The committee is amending this rule to add equipment application requirements, require MO SOS business registration documentation, require long-term care project affiliate and Medicare and/or Medicaid certification information, update DHSS bureau name information, decrease population estimate percentages, update form reference and add public notice requirements.

(2) A written application package consisting of an electronic file in PDF format or a paper original shall be prepared and organized as follows:

(B) The application package shall be based on one (1) of the following CON Applicant’s Completeness Checklists and Table of Contents appropriate to the proposed project type, as follows:

1. New Hospital Application (Form MO 580-2501), included herein. Use this for a new or replacement hospital project;
2. New or Additional Long-Term Care (LTC) Bed Application (Form MO 580-2502), included herein. Use this form for a Residential Care Facility project, Assisted Living Facility project, Intermediate Care Facility project, or Skilled Nursing Facility project or Long-Term Care Hospital project;
3. New or Additional Long-Term Care Hospital (LTCH) Bed Application (also use Form MO 580-2502), included herein;
4. New or Additional Equipment Application (Form MO 580-2503), included herein;
5. Expedited LTC Bed Replacement/Expansion Application (Form MO 580-2504), included herein;
6. Expedited LTC Renovation/Modernization Application (Form MO 580-2505), included herein; or
7. Equipment Replacement Application (Form MO 580-2506), included herein.

(C) The application shall be divided into these sections:

4. Divider IV. Financial Feasibility (only required for full applications or expedited replacement equipment applications which do not currently hold a valid CON).

(3) An Application Summary shall be composed of the completed forms in the following order:

(A) Applicant Identification and Certification (Form MO 580-1861), included herein. Additional specific information about board membership may be requested, if needed;
1. Provide documentation from the Missouri Secretary of State that the proposed owner(s) and proposed operator(s) are registered to do business in Missouri.
2. For long-term care projects:
   (I) State if the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years and;
   (II) If the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years, provide the name and address of the facility whose license was revoked;
(III) State if the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years and;

(IV) If the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years, provide the name and address of the facility whose Medicare and/or Medicaid certification was revoked.

(B) A completed Representative Registration (Form MO 580-1869), included herein, for the contact person and any others as required by section 197.326.1, RSMo;

(C) A detailed Proposed Project Budget (Form MO 580-1863), included herein; and

(4) The Proposal Description shall include documents which:

(C) Proposals for major medical equipment must define the geographic service area.

([CD]) Proposals for new hospitals[,] or new or additional long-term care (LTC) beds[, or new major medical equipment] must define the community to be served:

1. Describe the service area(s) population using year 2025 populations and projections provided by the Bureau of [Vital Statistics] Health Care Analysis and Data Dissemination (BHCADD) which can be obtained by contacting:

Chief, Bureau of [Vital Statistics] Health Care Analysis and Data Dissemination (BHCADD)

Section of Epidemiology for Public Health Practice (SEPHP)
Division of Community and Public Health
Department of Health and Senior Services
PO Box 570, Jefferson City, MO 65102
Telephone: (573) 751-6272

There will be a charge for any of the information requested, and seven to fourteen (7–14) days should be allowed for a response from [SEPHP] BHCADD. Information requests should be made to [SEPHP] the Bureau of Health Care Analysis and Data Dissemination (BHCADD) such that the response is received at least two (2) weeks before it is needed for incorporation into the CON application;

2. Use the maps and population data received from [SEPHP] BHCADD with the CON Applicant’s Population Determination Method to determine the estimated population for LTC projects, as follows:

D. Estimate, to the nearest [ten] five percent ([10][5%]), the portion of the zip code area that is within the fifteen- (15-) mile radius or geographic service area by “eyeballing” the portion of the area in the radius (if less than five percent (5%), exclude the entire zip code);

(6) Document that providers of similar health services in the proposed service area have been notified of the application by a public notice in the local newspaper of general circulation before it was filed with the CON Program [by] from the applicant. The public notice shall include a contact person’s name and phone number and/or email for the project.

(7) For proposed full or expedited Certificate of Need applications, excluding equipment replacement applications, document that administrators or directors of all affected facilities in the proposed fifteen (15)-mile radius or service area were addressed letters regarding the application.

([7][8]) In addition to using the Community Need Criteria and Standards as guidelines, the committee may also consider other factors to include, but not be limited to, the needs of residents based upon religious considerations, residents with HIV/AIDS, or mental health diagnoses, and special exceptions to the Community Need Criteria and Standards.
The following forms cited in this rule are incorporated by reference and published by the Certificate of Need Program (CONP), December 13, 2019, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a 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) New Hospital Application (Form MO 580-2501).
(B) New or Additional Long-Term Care (LTC) Bed Application (Form MO 580-2502).
(C) New or Additional Equipment Application (Form MO 580-2503).
(D) Expedited LTC Bed Replacement/Expansion Application (Form MO 580-2504).
(E) Expedited LTC Renovation/Modernization Application (Form MO 580-2505).
(F) Equipment Replacement Application (Form MO 580-2506).
(G) Applicant Identification and Certification (Form MO 580-1861).
(H) Representative Registration (Form MO 580-1869).
(I) Proposed Project Budget (Form MO 580-1863).


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

APPLICANT IDENTIFICATION AND CERTIFICATION

The information provided must match the **Letter of Intent** for this project, without exception.

### 1. Project Location
(Attach additional pages as necessary to identify multiple project sites.)

<table>
<thead>
<tr>
<th>Title of Proposed Project</th>
<th>Project Number</th>
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<table>
<thead>
<tr>
<th>Project Address (Street/City/State/Zip Code)</th>
<th>County</th>
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### 2. Applicant Identification
(Information must agree with previously submitted Letter of Intent.)

<table>
<thead>
<tr>
<th>List All Owner(s): (List corporate entity.)</th>
<th>Address (Street/City/State/Zip Code)</th>
<th>Telephone Number</th>
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<tr>
<th>List All Operator(s): (List entity to be licensed or certified.)</th>
<th>Address (Street/City/State/Zip Code)</th>
<th>Telephone Number</th>
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### 3. Ownership
(Check applicable category.)

- ☐ Nonprofit Corporation
- ☐ Individual
- ☐ City
- ☐ District
- ☐ Partnership
- ☐ Corporation
- ☐ County
- ☐ Other [__________]

### 4. Certification

In submitting this project application, the applicant understands that:

(A) The review will be made as to the community need for the proposed beds or equipment in this application;
(B) In determining community need, the Missouri Health Facilities Review Committee (Committee) will consider all similar beds or equipment within the service area;
(C) The issuance of a Certificate of Need (CON) by the Committee depends on conformance with its Rules and CON statute;
(D) A CON shall be subject to forfeiture for failure to incur an expenditure on any approved project six (6) months after the date of issuance, unless obligated or extended by the Committee for an additional six (6) months;
(E) Notification will be provided to the CON Program staff if and when the project is abandoned; and
(F) A CON, if issued, may not be transferred, relocated, or modified except with the consent of the Committee.

We certify the information and date in this application as accurate to the best of our knowledge and belief by our representative’s signature below:

### 5. Authorized Contact Person
(Attach a Contact Person Correction Form if different from the Letter of Intent.)

<table>
<thead>
<tr>
<th>Name of Contact Person</th>
<th>Title</th>
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<tr>
<th>Telephone Number</th>
<th>Fax Number</th>
<th>E-mail Address</th>
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<tr>
<th>Signature of Contact Person</th>
<th>Date of Signature</th>
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MO 580-1861 (03/13)
### Certificate of Need Program

**PROPOSED PROJECT BUDGET**

<table>
<thead>
<tr>
<th>Description</th>
<th>Dollars</th>
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<tbody>
<tr>
<td><strong>COSTS:</strong>*</td>
<td></td>
</tr>
<tr>
<td>1. New Construction Costs ***</td>
<td></td>
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<tr>
<td>2. Renovation Costs ***</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Subtotal Construction Costs</strong> (#1 plus #2)</td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>4. Architectural/Engineering Fees</td>
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<tr>
<td>5. Other Equipment (not in construction contract)</td>
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<tr>
<td>6. Major Medical Equipment</td>
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<tr>
<td>7. Land Acquisition Costs ***</td>
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<tr>
<td>8. Consultants’ Fees/Legal Fees ***</td>
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<tr>
<td>9. Interest During Construction (net of interest earned) ***</td>
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<tr>
<td>10. Other Costs ***</td>
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</tr>
<tr>
<td>11. <strong>Subtotal Non-Construction Costs</strong> (sum of #4 through #10)</td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
| 12. **Total Project Development Costs** (#3 plus #11) | **0** **

| **FINANCING:** | |
| 13. Unrestricted Funds | |
| 14. Bonds | |
| 15. Loans | |
| 16. Other Methods (specify) | |
| 17. **Total Project Financing** (sum of #13 through #16) | **0** **

| 18. New Construction Total Square Footage | |
| 19. New Construction Costs Per Square Foot ***** | |
| 20. Renovated Space Total Square Footage | |
| 21. Renovated Space Costs Per Square Foot ***** | |

*Attach additional page(s) detailing how each line item was determined, including all methods and assumptions used. Provide documentation of all major costs.*

** These amounts should be the same.

*** Capitalizable items to be recognized as capital expenditures after project completion.

**** Include as Other Costs the following: other costs of financing; the value of existing lands, buildings and equipment not previously used for health care services, such as a renovated house converted to residential care, determined by original cost, fair market value, or appraised value; or the fair market value of any leased equipment or building, or the cost of beds to be purchased.

***** Divide new construction costs by total new construction square footage.

****** Divide renovation costs by total renovation square footage.
**Certificate of Need Program**

**REPRESENTATIVE REGISTRATION**

(A registration form must be completed for each project presented.)

<table>
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<tr>
<th>Project Name</th>
<th>Number</th>
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(Please type or print legibly.)

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<tr>
<th>Name of Representative</th>
<th>Title</th>
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<tr>
<th>Firm/Corporation/Association of Representative [may be different from below, e.g., law firm, consultant, other]</th>
<th>Telephone Number</th>
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<th>Address (Street/City/State/Zip Code)</th>
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Who's interests are being represented?
(If more than one, submit a separate Representative Registration Form for each.)

<table>
<thead>
<tr>
<th>Name of Individual/Agency/Corporation/Organization being Represented</th>
<th>Telephone Number</th>
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<th>Address (Street/City/State/Zip Code)</th>
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Check one. Do you:

- Support
- Oppose
- Neutral

Relationship to Project:

- None
- Employee
- Legal Counsel
- Consultant
- Lobbyist

Other Information:

- Other (explain):

________________________________________________________________________

________________________________________________________________________

I attest that to the best of my belief and knowledge the testimony and information presented by me is truthful, represents factual information, and is in compliance with §197.326.1 RSMo which says: Any person who is paid either as part of his normal employment or as a lobbyist to support or oppose any project before the health facilities review committee shall register as a lobbyist pursuant to chapter 105 RSMo, and shall also register with the staff of the health facilities review committee for every project in which such person has an interest and indicate whether such person supports or opposes the named project. The registration shall also include the names and addresses of any person, firm, corporation or association that the person registering represents in relation to the named project. Any person violating the provisions of this subsection shall be subject to the penalties specified in §105.478, RSMo.

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<th>Original Signature</th>
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MO 580-1869 (11/01)
Certificate of Need Program

NEW HOSPITAL APPLICATION

Applicant’s Completeness Checklist and Table of Contents

Project Name: ___________________________ Project No: ___________________________

Project Description: _____________________________________________________________

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<th>Description</th>
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**Divider I.  Application Summary:**

1. Applicant Identification and Certification (Form MO 580-1861)
2. Representative Registration (From MO 580-1869)
3. Proposed Project budget (Form MO 580-1863) and detail sheet with documentation of costs.
4. Provide documentation from MO Secretary of State that the proposed owner(s) and operator(s) are registered to do business in MO.

**Divider II.  Proposal Description:**

1. Provide a complete detailed project description.
2. Provide the proposed number of licensed beds by medical specialty.
3. Provide a timeline of events for the project, from CON issuance through project competition.
4. Provide a legible city or county map showing the exact location of the proposed facility.
5. Provide a site plan for the proposed project.
6. Provide preliminary schematic drawings for the proposed project.
7. Provide evidence that architectural plans have been submitted to the Department of Health and Senior Services.
8. Provide the proposed square footage.
9. Document ownership of the project site, or provide an option to purchase.
10. Define the community to be served (service area: 2025 population, area, rationale).
11. Provide utilization projections through the first three (3) FULL years of operation of the new beds.
12. Identify specific community problems or unmet needs the proposal would address.
13. Provide the methods and assumptions used to project utilization.
14. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
15. Provide copies of any petitions, letters of support or opposition received.
16. Document that providers of similar health services in the proposed service area have been notified of the application by a public notice in the local newspaper.
17. Document that providers of all affected facilities in the proposed 15-mile radius were addressed letters regarding the application.

**Divider III.  Service Specific Criteria and Standards:**

1. Document the methodology utilized to determine the need for the proposed hospital.
2. Provide the most recent three (3) FULL years of evidence that the average occupancy of the same type(s) of beds at each other hospital in the proposed service area exceeds eighty percent (80%).
3. Discuss the impact the proposed hospital would have on utilization of other hospitals in the geographic service area.
4. Document the unmet need in the geographic service area for each type of bed being proposed according to the population-based need formula.

**Divider IV.  Financial Feasibility Review Criteria and Standards:**

1. Document that the proposed costs per square foot are reasonable when compared to the latest “RS Means Construction Cost data”
2. Document that sufficient financing is available by providing a letter from a financial institution or an auditor’s statement indicating that sufficient funds are available.
3. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) for the latest three (3) years, and projected through three (3) FULL years beyond project completion.
4. Document how patient charges are derived.
5. Document responsiveness to the needs of the medically indigent.
Project Name: __________________________  Project No: __________________________

**Application Summary:**

1. Applicant Identification and Certification (Form MO 580-1861)
2. Representative Registration (From MO 580-1869)
3. Proposed Project budget (Form MO 580-1863) and detail sheet with documentation of costs.
4. Provide documentation from MO Secretary of State that the proposed owner(s) and operator(s) are registered to do business in MO.
5. State if the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years.
6. If the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous 5 years, provide the name and address of the facility whose license was revoked.
7. State if the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous 5 years.
8. If the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous 5 years, provide the name and address of the facility whose Medicare and/or Medicaid certification was revoked.
9. Define the community to be served.
10. Provide 2025 population projections for the 15-mile radius service area.
11. Identify specific community problems or unmet needs the proposal would address.
12. Provide historical utilization for each of the past three (3) years and utilization projections through the first three (3) years of operation of the new LTC beds.
13. Provide the methods and assumptions used to project utilization.
14. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
15. Provide copies of any petitions, letters of support or opposition received.
16. Document that providers of similar health services in the proposed service area have been notified of the application by a public notice in the local newspaper.
17. Document that providers of all affected facilities in the proposed 15-mile radius were addressed letters regarding the application.

**Proposal Description:**

1. Provide a complete detailed project description.
2. Provide a timeline of events for the project, from CON issuance through project competition.
3. Provide a legible city or county map showing the exact location of the proposed facility.
4. Provide a site plan for the proposed project.
5. Provide preliminary schematic drawings for the proposed project.
6. Provide evidence that architectural plans have been submitted to the Department of Health and Senior Services.
7. Provide the proposed square footage.
8. Document ownership of the project site, or provide an option to purchase.
9. Define the community to be served.
10. Provide 2025 population projections for the 15-mile radius service area.
11. Identify specific community problems or unmet needs the proposal would address.
12. Provide historical utilization for each of the past three (3) years and utilization projections through the first three (3) years of operation of the new LTC beds.
13. Provide the methods and assumptions used to project utilization.
14. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
15. Provide copies of any petitions, letters of support or opposition received.
16. Document that providers of similar health services in the proposed service area have been notified of the application by a public notice in the local newspaper.
17. Document that providers of all affected facilities in the proposed 15-mile radius were addressed letters regarding the application.

**Service Specific Criteria and Standards:**

1. For ICF/SNF beds, address the population-based bed need methodology of fifty-three (53) beds per one thousand (1,000) population age sixty-five (65) and older.
2. For RCF/ALF beds, address the population-based bed need methodology of twenty-five (25) beds per one thousand (1,000) population age sixty-five (65) and older.
3. For LTCH beds, address the population-based bed need methodology of one-tenth (0.1) bed per one thousand (1,000) population.
4. Document any alternate need methodology used to determine the need for additional beds such as Alzheimer’s, mental health or other specialty beds.
5. For any proposed facility which is designed and operated exclusively for persons with acquired human immunodeficiency syndrome (AIDS) provide information to justify the need for the type of beds being proposed.
6. If the project is to add beds to an existing facility, has the facility received a Notice of Noncompliance within the last 18 months as a result of a survey, inspection or complaint investigation? If the answer is yes, explain.

**Financial Feasibility Review Criteria and Standards:**

1. Document that the proposed costs per square foot are reasonable when compared to the latest “RS Means Construction Cost data”
2. Document that sufficient financing is available by providing a letter from a financial institution or an auditor’s statement indicating that sufficient funds are available.
3. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) for the latest three (3) years, and projected through three (3) full years beyond project completion.
4. Document how patient charges are derived.
5. Document responsiveness to the needs of the medically indigent.
6. For a proposed new skilled nursing or intermediate care facility, what percentage of your admissions would be Medicaid eligible on the first day of admission or become Medicaid eligible within 90 days of admission?
7. For an existing skilled nursing or intermediate care facility, what percentage of your admissions are Medicaid eligible on the first day of admission or becomes Medicaid eligible within 90 days of admission.
Certificate of Need Program
NEW OR ADDITIONAL EQUIPMENT APPLICATION
Applicant’s Completeness Checklist and Table of Contents

Project Name: ________________________________
Project No: ________________________________

Project Description: ____________________________________________________________

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<th>Description</th>
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Divider I. Application Summary:
1. Applicant Identification and Certification (Form MO 580-1861)
2. Representative Registration (Form MO 580-1869)
3. Proposed Project Budget (Form MO 580-1863) and detail sheet with documentation of costs.

Divider II. Proposal Description:
1. Provide a complete detailed project description and include equipment bid quotes.
2. Provide a timeline of events for the project, from CON issuance through project competition.
3. Provide a legible city or county map showing the exact location of the project.
4. Define the community to be served and provide the geographic service area for the equipment.
5. Provide other statistics to document the size and validity of any user-defined geographic service area.
6. Identify specific community problems or unmet needs the proposal would address.
7. Provide the historical utilization for each of the past three years and utilization projections through the first three (3) FULL years of operation of the new equipment.
8. Provide the methods and assumptions used to project utilization.
9. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
10. Provide copies of any petitions, letters of support or opposition received.
11. Document that providers of similar health services in the proposed service area have been notified of the application by a public notice in the local newspaper.
12. Document that providers of all affected facilities in the proposed service area were addressed letters regarding the application.

Divider III. Service Specific Criteria and Standards:
1. For new units, address the minimum annual utilization standard for the proposed geographic service area.
2. For any new unit where specific utilization standards are not listed, provide documentation to justify the new unit.
3. For additional units, document compliance with the optimal utilization standard, and if not achieved, provide documentation to justify the additional unit.
4. For evolving technology address the following:
   - Medical effects as described and documented in published scientific literature;
   - The degree to which the objectives of the technology have been met in practice;
   - Any side effects, contraindications or environmental exposures;
   - The relationships, if any, to existing preventive, diagnostic, therapeutic or management technologies and the effects on the existing technologies;
   - Food and Drug Administration approval;
   - The need methodology used by this proposal in order to assess efficacy and cost impact of the proposal;
   - The degree of partnership, if any, with other institutions for joint use and financing.

Divider IV. Financial Feasibility Review Criteria and Standards:
1. Document that sufficient financing is available by providing a letter from a financial institution or an auditor’s statement indicating that sufficient funds are available.
2. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) projected through three (3) FULL years beyond project completion.
3. Document how patient charges are derived.
4. Document responsiveness to the needs of the medically indigent.
**Certificate of Need Program**

**EXPEDITED LTC BED REPLACEMENT/EXPANSION APPLICATION**

Applicant’s Completeness Checklist and Table of Contents

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**Divider I. Application Summary:**

1. Applicant Identification and Certification (Form MO 580-1861).
2. Representative Registration (Form MO 580-1869).
3. Proposed Project Budget (Form MO 580-1863) and detail sheet with documentation of costs.

**Divider II. Proposal Description:**

1. Provide a complete detailed project description.
2. Provide a timeline of events for the project, from the issuance of the CON through project completion.
3. Provide preliminary schematic drawings for the proposed project.
4. Provide the existing and proposed gross square footage.
5. Document ownership of the project site.

**Divider III. Community Need Criteria and Standards:**

1. If the proposal is to relocate RCF/ALF beds within 6-mile radius in accordance with §197.318.4(4) provide the following:
   - Documentation that all facilities involved are under the same licensure ownership or control;
   - Documentation that all facilities involved are within the 6-mile limit; and
   - Documentation that all owners and operators of the facility from which the beds are being transferred are aware of the proposal and consent to it.

2. If the proposal is to replace one-half of a qualifying licensed facility’s beds within a 30-mile radius in accordance with §197.318.5 provide the following:
   - Documentation that the facility has only been operating 50% of its licensed capacity with every resident residing in a private room and all vacant beds have been reported to the Division of Regulation and Licensure as unavailable for occupancy for at least the most recent four consecutive calendar quarters;
   - Documentation that the replacement beds shall be built to private room specifications and only used for single occupancy; and
   - Documentation that the existing and proposed facilities have the same owner or owners, and that the owner or owners stipulate that the beds to be replaced shall not be used later for long term care; if the existing facility is being operated under a lease, both the lessee and owner shall stipulate the same.

3. If the proposal is to replace a facility in its entirety at a single site within a 15-mile radius in accordance with §197.318.6 provide the following:
   - Documentation that all facilities involved are within the 15-mile limit; and
   - Documentation that the existing facility and the proposed facility have the same owner or owners with a written stipulation that the facility to be replaced will not be used later for a long term care.

4. If the proposal is to expand under provisions of §197.318.4(1) and the effort to purchase has been successful provide:
   - Purchase Agreement Form(s) (MO 580-2352); and
   - A copy of the selling facility’s reissued license verifying surrender of beds sold.

5. If the proposal is to expand under provisions of §197.318.4(1) and effort(s) to purchase have been unsuccessful, provide Purchase Agreement Form(s) (MO 580-2352) verifying unsuccessful effort(s) to purchase.
### Application Summary:
- **1.** Applicant Identification and Certification (Form MO 580-1861).
- **2.** Representative Registration (Form MO 580-1869).
- **3.** Proposed Project Budget (Form MO 580-1863) and detail sheet with documentation of costs.

### Proposal Description:
- **1.** Provide a complete detailed project description.
- **2.** Provide a timeline of events for the project, from the issuance of the CON through project completion.
- **3.** Provide preliminary schematic drawings for the proposed project.
- **4.** Provide the existing and proposed gross square footage.
- **5.** Document ownership of the project site.

### Community Need Criteria and Standards:
- **1.** Indicate whether the proposed project is needed to comply with current facility code requirements of local, state or federal governments.
- **2.** Indicate whether the proposed project is needed to meet requirements for licensure, certification or accreditation, which if not undertaken, could result in a loss of accreditation or certification.
- **3.** Describe any operational efficiencies to be attained through reconfiguration of space and functions.
- **4.** Describe the methodologies used for determining need.
- **5.** Provide the rationale for the reallocation of space and functions.
Certificate of Need Program

EQUIPMENT REPLACEMENT APPLICATION

Applicant’s Completeness Checklist and Table of Contents

<table>
<thead>
<tr>
<th>Dividers</th>
<th>Application Summary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>1. Applicant Identification and Certification (Form MO 580-1861)</td>
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<td>________</td>
<td>2. Representative Registration (From MO 580-1869)</td>
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<th>Proposal Description:</th>
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<tbody>
<tr>
<td>________</td>
<td>1. Provide a complete detailed project description, CON project number of the existing equipment (if prev. CON approved), and include the type/brand of both the existing equipment and the replacement equipment.</td>
</tr>
<tr>
<td>________</td>
<td>2. Provide a listing with itemized costs of the medical equipment to be acquired and bid quotes.</td>
</tr>
<tr>
<td>________</td>
<td>3. Provide a timeline of events for the project, from CON issuance through project completion.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Dividers</th>
<th>Service Specific Criteria and Standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>1. Describe the financial rationale for the proposed replacement equipment.</td>
</tr>
<tr>
<td>________</td>
<td>2. Document if the existing equipment has exceeded its useful life.</td>
</tr>
<tr>
<td>________</td>
<td>3. Describe the effect the replacement unit would have on quality of care.</td>
</tr>
<tr>
<td>________</td>
<td>4. Document if the existing equipment is in constant need of repair.</td>
</tr>
<tr>
<td>________</td>
<td>5. Document if the lease on the current unit has expired.</td>
</tr>
<tr>
<td>________</td>
<td>6. Describe the technological advances provided by the new unit.</td>
</tr>
<tr>
<td>________</td>
<td>7. Describe how patient satisfaction would be improved.</td>
</tr>
<tr>
<td>________</td>
<td>8. Describe how patient outcomes would be improved.</td>
</tr>
<tr>
<td>________</td>
<td>9. Describe what impact the new unit would have on utilization.</td>
</tr>
<tr>
<td>________</td>
<td>10. Describe any new capabilities that the new unit would provide.</td>
</tr>
<tr>
<td>________</td>
<td>11. By what percent will this replacement increase patient charges.</td>
</tr>
</tbody>
</table>

*(If replacement equipment was not previously approved, also complete Divider IV below.)*

<table>
<thead>
<tr>
<th>Dividers</th>
<th>Financial Feasibility Review Criteria and Standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>1. Document that sufficient financing is available by providing a letter from a financial institution or an auditor’s statement indicating that sufficient funds are available.</td>
</tr>
<tr>
<td>________</td>
<td>2. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) projected through three (3) FULL years beyond project completion.</td>
</tr>
<tr>
<td>________</td>
<td>3. Document how patient charges are derived.</td>
</tr>
<tr>
<td>________</td>
<td>4. Document responsiveness to the needs of the medically indigent.</td>
</tr>
</tbody>
</table>