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 60-50.430 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.**

([*C*]D) 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.

[*(8) 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).]

AUTHORITY: section 197.320, RSMo 2016. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule 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. Rescinded and readopted: Filed Dec. 14, 2001, effective June 30, 2002. Emergency rescission and rule filed Dec. 16, 2002, effective Jan. 1, 2003, expired June 29, 2003. Amended: Filed June 9, 2003, effective Nov. 30, 2003. Emergency amendment filed June 8, 2005, effective July 1, 2005, expired Dec. 30, 2005. Amended: Filed June 8, 2005, effective Dec. 30, 2005. 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 March 10, 2014, effective Oct. 30, 2014. 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

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.)*

Title of Proposed Project	Project Number
Project Address *(Street/City/State/Zip Code)*	County

2. Applicant Identification *(Information must agree with previously submitted Letter of Intent.)*

List All Owner(s): *(List corporate entity.)*	Address (Street/City/State/Zip Code)	Telephone Number

List All Operator(s): *(List entity to be licensed or certified.)*	Address (Street/City/State/Zip Code)	Telephone Number

3. Ownership *(Check applicable category.)*

⌋ Nonprofit Corporation	Δ Individual	Δ City	Δ District
⌋ Partnership	Δ Corporation	Δ County	Δ 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.)*

Name of Contact Person		Title
Telephone Number	Fax Number	E-mail Address
Signature of Contact Person		Date of Signature

Certificate of Need Program

PROPOSED PROJECT BUDGET

Description	Dollars
COSTS:*	*(Fill in every line, even if the amount is "$0".)*
1. New Construction Costs ***	
2. Renovation Costs ***	
3. **Subtotal Construction Costs** (#1 plus #2)	$0
4. Architectural/Engineering Fees	
5. Other Equipment (not in construction contract)	
6. Major Medical Equipment	
7. Land Acquisition Costs ***	
8. Consultants' Fees/Legal Fees ***	
9. Interest During Construction (net of interest earned) ***	
10. Other Costs ***	
11. **Subtotal Non-Construction Costs** (sum of #4 through #10	$0
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.)*	
Project Name	Number
(Please type or print legibly.)	
Name of Representative	Title
Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other)	Telephone Number
Address (Street/City/State/Zip Code)	

Who's interests are being represented?
(If more than one, submit a separate Representative Registration Form for each.)

Name of Individual/Agency/Corporation/Organization being Represented	Telephone Number
Address (Street/City/State/Zip Code)	

Check one. Do you:

- Δ Support
- Δ Oppose
- Δ Neutral

Relationship to Project:

- Δ None
- Δ Employee
- Δ Legal Counsel
- Δ Consultant
- Δ Lobbyist
- Δ Other (explain): ______________________

Other Information: ______________________

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.*

Original Signature	Date

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:______________________________

Done Page N/A Description

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.

NEW OR ADDITIONAL LONG TERM CARE BED APPLICATION (*Use for RCF/ALF, ICF/SNF and LTCH beds]*

Applicant's Completeness Checklist and Table of Contents

Project Name:________________________ Project No:________________

Project Description:____

Done Page N/A Description

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.
__ ________ __ 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.

Divider II. 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) **FULL** 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.

Divider III. 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.

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.
__ ________ __ 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:______________________________________

Done Page N/A Description

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.

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

Project Name:______________________________ Project No:____________

Project Description:______________________________

Done Page N/A Description

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.

Certificate of Need Program

EXPEDITED LTC RENOVATION/MODERNIZATION APPLICATION

Applicant's Completeness Checklist and Table of Contents

Project Name:______________________________ Project No:______________

Project Description:____

Done Page N/A Description

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. 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

Project Name:______________________________ Project No:______________________

Project Description:____

Done Page N/A Description

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.

Divider II. Proposal Description:

____________ __ 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.

____________ __ 2. Provide a listing with itemized costs of the medical equipment to be acquired and bid quotes.

____________ __ 3. Provide a timeline of events for the project, from CON issuance through project completion.

Divider III. Service Specific Criteria and Standards:

____________ __ 1. Describe the financial rationale for the proposed replacement equipment.

____________ __ 2. Document if the existing equipment has exceeded its useful life.

____________ __ 3. Describe the effect the replacement unit would have on quality of care.

____________ __ 4. Document if the existing equipment is in constant need of repair.

____________ __ 5. Document if the lease on the current unit has expired.

____________ __ 6. Describe the technological advances provided by the new unit.

____________ __ 7. Describe how patient satisfaction would be improved.

____________ __ 8. Describe how patient outcomes would be improved.

____________ __ 9. Describe what impact the new unit would have on utilization.

____________ __ 10. Describe any new capabilities that the new unit would provide.

____________ __ 11. By what percent will this replacement increase patient charges.

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

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.