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.
			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 gross square footage.
☐	_____	☐	8. Document ownership of the project site, or provide an option to purchase.
☐	_____	☐	9. Define the community to be served (service area: 2025 population, area, rationale)
☐	_____	☐	10. Provide utilization estimates for the first **FULL** three years of operation following project completion.
☐	_____	☐	11. Provide the methods and assumptions used to project utilization.
☐	_____	☐	12. Provide the proposed number of licensed beds by medical specialty.
☐	_____	☐	13. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
☐	_____	☐	14. Provide copies of any petitions, letters of support or opposition received
			Divider III. Community Need Criteria and Standards:
☐	_____	☐	1. Document the methodology utilized to determine the need for the proposed hospital.
☐	_____	☐	2. Document that the current occupancy of other hospitals in the proposed geographic service area exceeds 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 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.

Use for New or Replacement Hospital