



# **Application for Certificate of Need**

**St. Luke's Radiation Therapy-Liberty LLC  
Relocate Linear Accelerator**

Project #6125 HS

**Submitted to  
Missouri Health Facilities Review Committee**

June 2024



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 completion.
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.

**Divider I. Application Summary:**

***1. Applicant Identification and Certification (Form MO 580-1861).***

See attached.

***2. Representative Registration (Form MO 580-1869).***

See attached.

***3. Proposed Project Budget (Form MO 580-1863) and detail sheet.***

See attached.



Certificate of Need Program

**APPLICANT IDENTIFICATION AND CERTIFICATION**

<i>The information provided must match the <b>Letter of Intent</b> for this project, without exception.</i>		
<b>1. Project Location</b> <i>(Attach additional pages as necessary to identify multiple project sites.)</i>		
<small>Title of Proposed Project</small> Saint Luke's Radiation Therapy - Liberty, LLC-relocate linear accelerator	<small>Project Number</small> 6125HS	
<small>Project Address (Street/City/State/Zip Code)</small> 5830 NW Barry Road, Kansas City, MO 64154	<small>County</small> Platte	
<b>2. Applicant Identification</b> <i>(Information must agree with previously submitted Letter of Intent.)</i>		
<b>List All Owner(s):</b> <i>(List corporate entity.)</i> <small>Address (Street/City/State/Zip Code)</small> <small>Telephone Number</small>		
Saint Luke's Radiation Therapy - Liberty, LLC	5830 NW Barry Road, Kansas City, MO 64154	314-323-1231
<small>(List entity to be licensed or certified.)</small>		
<b>List All Operator(s):</b> <i>(List entity to be licensed or certified.)</i> <small>Address (Street/City/State/Zip Code)</small> <small>Telephone Number</small>		
Saint Luke's Radiation Therapy - Liberty, LLC	5830 NW Barry Road, Kansas City, MO 64154	314-323-1231
<b>3. Ownership</b> <i>(Check applicable category.)</i>		
<input checked="" type="checkbox"/> Nonprofit Corporation <input type="checkbox"/> Individual <input type="checkbox"/> City <input type="checkbox"/> District <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> County <input type="checkbox"/> Other _____		
<b>4. Certification</b>		
In submitting this project application, the applicant understands that: <ul style="list-style-type: none"> <li>(A) The review will be made as to the community need for the proposed beds or equipment in this application;</li> <li>(B) In determining community need, the Missouri Health Facilities Review Committee (Committee) will consider all similar beds or equipment within the service area;</li> <li>(C) The issuance of a Certificate of Need (CON) by the Committee depends on conformance with its Rules and CON statute;</li> <li>(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;</li> <li>(E) Notification will be provided to the CON Program staff if and when the project is abandoned; and</li> <li>(F) A CON, if issued, may not be transferred, relocated, or modified except with the consent of the Committee.</li> </ul> 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:		
<b>5. Authorized Contact Person</b> <i>(Attach a Contact Person Correction Form if different from the Letter of Intent.)</i>		
<small>Name of Contact Person</small> Greg Bratcher	<small>Title</small> Dir., Government Relations	
<small>Telephone Number</small> 314-323-1231	<small>Fax Number</small>	<small>E-mail Address</small> gbratcher@bjc.org
<small>Signature of Contact Person</small> 		<small>Date of Signature</small> 6/26/2024



Certificate of Need Program

**REPRESENTATIVE REGISTRATION**

<i>(A registration form must be completed for <b>each</b> project presented.)</i>	
Project Name Saint Luke's Radiation Therapy - Liberty, LLC-relocate linear accelerator	Number 6125HS
<i>(Please type or print legibly.)</i>	
Name of Representative Greg Bratcher	Title Dir., Gov. Relations
Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other) BJC HealthCare	Telephone Number 314-323-1231
Address (Street/City/State/Zip Code) 4901 Forest Park Ave, Suite 1220, MS 90-75-574, St. Louis, MO 63108	
Who's interests are being represented? <i>(If more than one, submit a separate Representative Registration Form for each.)</i>	
Name of Individual/Agency/Corporation/Organization being Represented BJC HealthCare	Telephone Number 314-323-1231
Address (Street/City/State/Zip Code) 4901 Forest Park Ave, Suite 1220, MS 90-75-574, St. Louis, MO 63108	
Check one. Do you: <input checked="" type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Neutral  Other Information:  _____ _____	Relationship to Project: <input type="checkbox"/> None <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Legal Counsel <input type="checkbox"/> Consultant <input type="checkbox"/> Lobbyist <input type="checkbox"/> 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: <i>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.</i>	
Original Signature 	Date 6/26/2024



Certificate of Need Program  
**PROPOSED PROJECT BUDGET**

<u>Description</u>	<u>Dollars</u>								
<b>COSTS:*</b>	<i>(Fill in every line, even if the amount is "\$0".)</i>								
1. New Construction Costs ***	_____								
2. Renovation Costs ***	_____								
<b>3. Subtotal Construction Costs (#1 plus #2)</b>	_____								
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 ***	_____								
<b>11. Subtotal Non-Construction Costs</b> (sum of #4 through #10)	_____								
<b>12. Total Project Development Costs</b> (#3 plus #11)	_____ <b>**</b>								
 <b>FINANCING:</b>									
13. Unrestricted Funds	_____								
14. Bonds	_____								
15. Loans	_____								
16. Other Methods (specify)	_____								
<b>17. Total Project Financing</b> (sum of #13 through #16)	_____ <b>**</b>								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">18. New Construction Total Square Footage</td> <td style="width: 20%; text-align: right;">_____</td> </tr> <tr> <td>19. New Construction Costs Per Square Foot *****</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>20. Renovated Space Total Square Footage</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>21. Renovated Space Costs Per Square Foot *****</td> <td style="text-align: right;">_____</td> </tr> </table>		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 *****	_____
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 *****	_____								
<p>* Attach additional page(s) detailing how each line item was determined, including all methods and assumptions used. Provide documentation of all major costs.</p> <p>** These amounts should be the same.</p> <p>*** Capitalizable items to be recognized as capital expenditures after project completion.</p> <p>**** 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.</p> <p>***** Divide new construction costs by total new construction square footage.</p> <p>***** Divide renovation costs by total renovation square footage.</p>									

**Move Linear Accelerator Northland**

Budget detail

<b>Project Component</b>	<b>Cost</b>
Book Value, TrueBeam, 7 yrs.	\$481,250.00
Modify Existing Vault & Door	\$814,818.00
Move Linear Accelerator	\$302,000.00
Testing & Commissioning	\$76,296.00
<b>TOTAL</b>	<b>\$1,674,364.00</b>

## Divider II. Proposal Description:

### *1. Provide a complete detailed project description.*

St. Luke's Radiation Therapy-Liberty LLC proposes to relocate a linear accelerator in Kansas City's Northland. Since the early 2000s St. Luke's has partnered with Liberty Hospital to deliver radiation therapy on the campus of Liberty Hospital. Before that, in conjunction with the same physician group, St. Luke's provided these services on its own campus—in the very vault proposed for this transfer. In a metaphorical sense, this machine is just coming home.

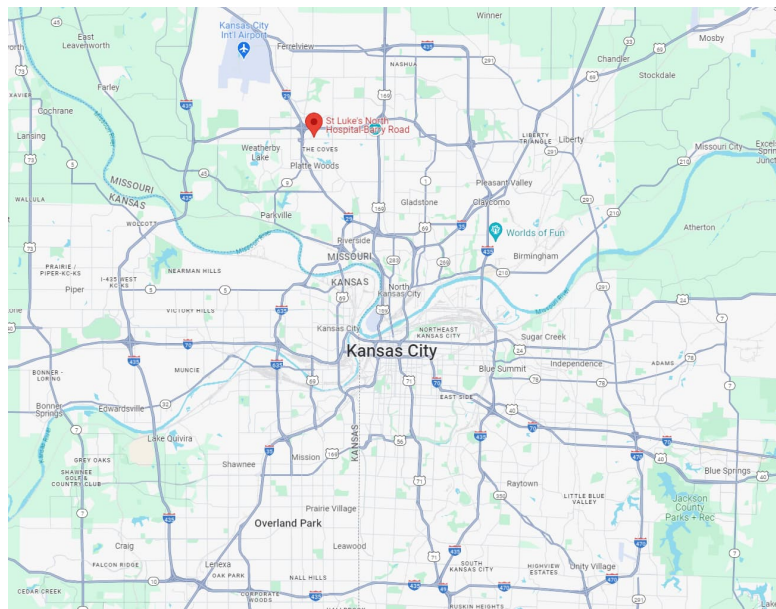
The original linear accelerator tied to this project was approved by the Committee in 2003 as CON #3352FS. Then, after about fifteen years of operation, that machine was replaced under the authority of CON #5502HT, filed in 2017. It is this machine we propose to move. It is a Siemens TrueBeam linear accelerator.

The estimated project cost includes the remaining book value of the machine, the costs to move the machine, and the costs to modify the existing vault and door. This cost is \$1,674,364.

### *2. Provide a timeline of events for the project, from CON issuance through project competition.*

- Prepare linear accelerator for move: February 2025
- Move and install the machine at new location: March 2025
- Calibration and testing: April 2025
- Start Treatments: May 2025

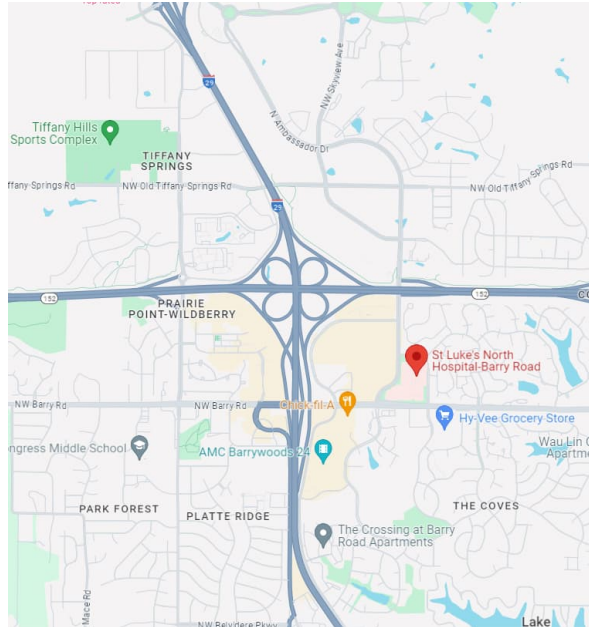
### *3. Provide a legible city or county map showing the exact location of the project.*





**4. Define the community to be served and provide the geographic service area for the equipment.**

Clay and Platte Counties are generally known as the Northland in metro Kansas City. This is the current service area for the machine and remains as such. There is no new service area; the move simply improves access by locating the unit at the intersection of the two major arteries in the Northland rather than at the very eastern edge of the service area.



**5. Provide other statistics to document the size and validity of any user-defined geographic service area.**

Clay County is rapidly growing. It is second in the state both in the absolute magnitude of growth and in its rate of growth. Platte County is in the top twenty. The Northland could be home to half a million in a decade. The linear accelerator is already in this community. We seek only to move it onto the hospital's campus, closer to the major arteries crisscrossing the region.

**Service Area Population**

County	2000 from Office of Admin	2025 CON Required Projection	2030 from Office of Admin	% Change 2000 to 2030
Clay	184,006	269,569	300,021	63.0%
Platte	73,781	117,165	114,904	55.7%
	<b>257,787</b>	<b>386,734</b>	<b>414,925</b>	<b>61.0%</b>

Sources: Mo. Dept. Of Health & Senior Services and Mo. Dept. of Administration

**6. Identify specific community problems or unmet needs the proposal would address.**

The community has been well served by the applicant for over two decades. This project seeks to allow for the continuous operation of the linear accelerator while relocating it to the main Northland campus of St. Luke's. This location provides better highway access for a greater portion of the Northland.

**7. Provide historical utilization for each of the past three years and utilization projections through the first three years of operation of the new equipment.**

Historical and projected volume is as follows:

2021	2022	2023	2024	2025	2026	2027	2028
4,393	5,401	5,722	6,005	4,243	4,455	4,678	4,912

**8. Provide the methods and assumptions used to project utilization.**

Saint Luke's, as a long-time owner of the joint venture, has extensive experience treating cancer and operating the linear accelerator. The projections in this application are based on this expertise. They're based on the actual experience with this machine.

**9. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.**

Saint Luke's has a board comprised of community and business leaders. This group's counsel has been solicited, and many of their ideas have been incorporated into components of the project. As is a standard process throughout BJC, departmental planning teams incorporate feedback from doctors and patient-care staff, who aggregate patients' needs and preferences. Furthermore, all Saint Luke's Health System entities continuously monitor consumer preferences and research patient needs. Saint Luke's has continuously shown some of the best patient satisfaction rates in the metropolitan area, partly due to an ongoing partnership between community members and the health system.

**10. Provide copies of any petitions, letters of support or opposition received.**

Letters attached.

**11. Document that providers have been notified of the application by a public notice in the local newspaper.**

A public notice seeking comment has been published in the *Kansas City Star* and was also posted to the paper's website.

***12. Document that providers of all affected facilities were addressed letters regarding the application.***

Sent via separate email is a folder with an Excel file showing the list of recipients of this notice and a copy of the “sent” receipt for each recipient. The text of the notice is included in the receipts.

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

*1. For new units address the need formula for the proposed geographic service area.*

Unfortunately, there is no CON application template for relocating a piece of equipment. Nevertheless, since this machine would be at a new address, and CONs are address-specific, a CON is required. The closest match is the “new equipment” CON template. However, there will be no new units in the service area.

There are three linear accelerators in the Northland region, with ours being the last line in the table:

**BEFORE**

University of Kansas Cancer Center	8700 N. Green Hills Road, Kansas City, Missouri 64154
North Kansas City Hospital	2800 Clay Edwards Drive, North Kansas City, Missouri 64116
St. Luke’s Radiation Therapy-Liberty LLC	2529 Glenn Hendren Dr. Liberty 64068

When the project is complete, the only difference is the address of the last unit:

**AFTER**

University of Kansas Cancer Center	8700 N. Green Hills Road, Kansas City, Missouri 64154
North Kansas City Hospital	2800 Clay Edwards Drive, North Kansas City, Missouri 64116
St. Luke’s Radiation Therapy-Liberty LLC	2529 Glenn Hendren Dr. Liberty 640685830 NW Barry Rd, Kansas City, MO 64154

*2. For new units, address the minimum annual utilization standard for the proposed geographic service area.*

Only one of the other two linear accelerators reports volume through the annual hospital licensing survey, North Kansas City Hospital. In 2022 they recorded 7,690 procedures, well over the CON criterion of 3,600 procedures per machine.

*3. For any new unit where specific need and utilization standards are not listed provide the methodology for determining need.*

NA

*4. For additional units, document compliance with the optimal utilization standard, and if not achieved, provide documentation to justify the additional unit.*

NA

**5. For evolving technology address the following:**

- Medical effects as described and documented in published scientific literature;

NA

- The degree to which the objectives of the technology have been met in practice;

NA

- Any side effects, contraindications or environmental exposures;

NA

- The relationships, if any, to existing preventive, diagnostic, therapeutic or management technologies and the effects on the existing technologies;

NA

- Food and Drug Administration approval;

NA

- The need methodology used by this proposal in order to assess efficacy and cost impact of the proposal; and

NA

- The degree of partnership, if any, with other institutions for joint use and financing.

NA

**Divider IV. Financial Feasibility Review Criteria & 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.***

The audited statements for St. Luke's Health System were provided in a previous application.

***2. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) projected through three (3) years beyond project completion.***

See attached financial forms.

***3. Document how patient charges were derived.***

Patient charges are generally derived by accumulating all the costs of services, including staff and supplies utilized during the course of the visit. Charges for each procedure are derived from the current charge description master and are dependent on the types of procedures performed along with several other variables.

***4. Document responsiveness to the needs of the medically indigent.***

BJC is the largest provider of charity care, unreimbursed care, and community benefits in the state of Missouri. The recent A copy of St. Luke's existing policy for meeting the needs of the medically indigent is on file, having been included in a previous application.



## Certificate of Need Program

**SERVICE-SPECIFIC REVENUES AND EXPENSES****Project Title:****Project #:****Historical Financial Data for Latest Three Full Years plus Projections Through Three Full Years Beyond Project Completion**

Use an individual form for each affected service with a sufficient number of copies of this form to cover entire period, and fill in the years in the appropriate blanks.

	<b>Year</b>		
	<u>2021</u>	<u>2022</u>	<u>2023</u>
<b>Amount of Utilization:*</b>	4,393	5,401	5,722
<b>Revenue:</b>			
Average Charge**	\$7,633	\$7,297	\$7,172
Gross Revenue	\$33,531,769	\$39,411,097	\$41,038,184
Revenue Deductions	29,272,055	32,579,143	34,010,566
Operating Revenue	4,259,714	6,831,954	7,027,618
Other Revenue	133,869	521,030	12,225
<b>TOTAL REVENUE</b>	<b>\$4,393,583</b>	<b>\$7,352,984</b>	<b>\$7,039,843</b>
<b>Expenses:</b>			
Direct Expenses			
Salaries	1,055,695	1,101,664	1,139,290
Fees	595,000	595,000	595,000
Supplies	1,299,361	1,841,383	2,003,276
Other	198,473	202,647	207,557
<b>TOTAL DIRECT</b>	<b>\$3,148,529</b>	<b>\$3,740,694</b>	<b>\$3,945,123</b>
Indirect Expenses			
Depreciation	596,059	559,976	478,631
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	0	0	0
<b>TOTAL INDIRECT</b>	<b>\$596,059</b>	<b>\$559,976</b>	<b>\$478,631</b>
<b>TOTAL EXPENSES</b>	<b>\$3,744,588</b>	<b>\$4,300,670</b>	<b>\$4,423,754</b>
<b>NET INCOME (LOSS):</b>	<b>\$648,995</b>	<b>\$3,052,314</b>	<b>\$2,616,089</b>

\*Utilization will be measured in "patient days" for licensed beds, "procedures" for equipment, or other appropriate units of measure specific to the service affected.

\*\*Indicate how the average charge/procedure was calculated.

\*\*\*Only on long term debt, not construction.

\*\*\*\*Indicate how overhead was calculated.



Certificate of Need Program

**SERVICE-SPECIFIC REVENUES AND EXPENSES**

**Project Title:**

**Project #:**

**Historical Financial Data for Latest Three Full Years plus Projections Through Three Full Years Beyond Project Completion**

*Use an individual form for each affected service with a sufficient number of copies of this form to cover entire period, and fill in the years in the appropriate blanks.*

	<b>Year</b>		
	<u>2024</u>	<u>2025</u>	<u>2026</u>
<b>Amount of Utilization:*</b>	6,005	4,243	4,455
<b>Revenue:</b>			
Average Charge**	\$7,713	\$7,733	\$7,733
Gross Revenue	\$46,316,565	\$32,811,119	\$34,450,515
Revenue Deductions	37,880,806	26,409,774	27,966,812
Operating Revenue	<u>8,435,759</u>	<u>6,401,345</u>	<u>6,483,703</u>
Other Revenue	=	=	=
<b>TOTAL REVENUE</b>	<b><u>\$8,435,759</u></b>	<b><u>\$6,401,345</u></b>	<b><u>\$6,483,703</u></b>
<b>Expenses:</b>			
Direct Expenses			
Salaries	1,286,736	1,051,533	1,088,336
Fees	595,000	595,000	595,000
Supplies	3,064,858	1,703,226	1,604,109
Other	212,263	74,640	76,880
<b>TOTAL DIRECT</b>	<u>\$5,158,857</u>	<u>\$3,424,399</u>	<u>\$3,364,325</u>
Indirect Expenses			
Depreciation	432,521	422,346	165,682
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	0	0	0
<b>TOTAL INDIRECT</b>	<u>\$432,521</u>	<u>\$422,346</u>	<u>\$165,682</u>
<b>TOTAL EXPENSES</b>	<b><u>\$5,591,378</u></b>	<b><u>\$3,846,745</u></b>	<b><u>\$3,530,007</u></b>
<b>NET INCOME (LOSS):</b>	<b><u>\$2,844,381</u></b>	<b><u>\$2,554,600</u></b>	<b><u>\$2,953,696</u></b>

\*Utilization will be measured in "patient days" for licensed beds, "procedures" for equipment, or other appropriate units of measure specific to the service affected.

\*\*Indicate how the average charge/procedure was calculated.

\*\*\*Only on long term debt, not construction.

\*\*\*\*Indicate how overhead was calculated.





Certificate of Need Program

**SERVICE-SPECIFIC REVENUES AND EXPENSES**

**Project Title:**

**Project #:**

**Historical Financial Data for Latest Three Full Years plus Projections Through Three Full Years Beyond Project Completion**

*Use an individual form for each affected service with a sufficient number of copies of this form to cover entire period, and fill in the years in the appropriate blanks.*

**Year**

**Amount of Utilization:\***

--	--	--

**Revenue:**

Average Charge\*\*

--	--	--

Gross Revenue

--	--	--

Revenue Deductions

--	--	--

Operating Revenue

--	--	--

Other Revenue

--	--	--

**TOTAL REVENUE**

--	--	--

**Expenses:**

Direct Expenses

Salaries

--	--	--

Fees

--	--	--

Supplies

--	--	--

Other

--	--	--

TOTAL DIRECT

--	--	--

Indirect Expenses

Depreciation

--	--	--

Interest\*\*\*

--	--	--

Rent/Lease

--	--	--

Overhead\*\*\*\*

--	--	--

TOTAL INDIRECT

--	--	--

**TOTAL EXPENSES**

--	--	--

**NET INCOME (LOSS):**

--	--	--

\*Utilization will be measured in "patient days" for licensed beds, "procedures" for equipment, or other appropriate units of measure specific to the service affected.

\*\*Indicate how the average charge/procedure was calculated.

\*\*\*Only on long term debt, not construction.

\*\*\*\*Indicate how overhead was calculated.

**THANK YOU for your ad submission!**

This is your confirmation that your order has been submitted. Below are the details of your transaction. Please save this confirmation for your records. This transaction will show up on your credit card statement as McClatchy.

For any questions, please contact us directly by email: [c3legals@mcclatchy.com](mailto:c3legals@mcclatchy.com)

**Job Details**

Order Number:  
**IPL0181555**  
Classification:  
Legals & Public Notices

Package:  
KCM - Legal Ads  
Order Cost:  
\$168.40

Payment Type:  
Visa

**Account Details**

Lindsey Stringer  
12208 Westgate Street  
Overland Park, KS ♦ 66213  
816-244-9821  
[lstringer@saint-lukes.org](mailto:lstringer@saint-lukes.org)  
Credit Card - Visa \*\*\*\*\*3484

**Schedule for ad number IPL01815550**

Sun Jun 30, 2024  
**The Kansas City Star**  
All Zones

**Certificate of Need**

St. Luke's North Hosp. & St. Luke's Radiation Therapy-Liberty LLC will apply to the Mo. Health Fac. Review Comm. to move a linear accelerator from Liberty Hospital to the hospital campus on NW Barry Rd. Contact Greg Bratcher at [gbratcher@bjc.org](mailto:gbratcher@bjc.org) with any comments or questions.  
IPL0181555  
Jun 30 2024



4401 Wornall Road  
Kansas City, MO 64111  
816-932-2000

June 27, 2024

Dear Dr. Reintjes:

As part of the Missouri Certificate of Need process, applicants are asked to notify those within the project's service area when applying for a certificate. In a forthcoming application, we propose to move the linear accelerator located on the campus of Liberty Hospital to our Saint Luke's North Hospital campus on Barry Road.

To be clear, we are simply moving the existing machine—there will be no new unit in the service area. Since CONs are address-specific, we need a new CON for the new location.

If you should have any questions or concerns, please do not hesitate to call me at (816) 932-9841.

Respectfully,

A handwritten signature in black ink that reads "Jani Johnson".

Jani Johnson, RN, MSN  
Chief Executive Officer  
Saint Luke's Central Region



4401 Wornall Road  
Kansas City, MO 64111  
816-932-2000

June 27, 2024

Dear Mr. Wright:

As part of the Missouri Certificate of Need process, applicants are asked to notify those within the project's service area when applying for a certificate. In a forthcoming application, we propose to move the linear accelerator located on the campus of Liberty Hospital to our Saint Luke's North Hospital campus on Barry Road.

To be clear, we are simply moving the existing machine—there will be no new unit in the service area. Since CONs are address-specific, we need a new CON for the new location.

If you should have any questions or concerns, please do not hesitate to call me at (816) 932-9841.

Respectfully,

A handwritten signature in black ink that reads "Jani Johnson".

Jani Johnson, RN, MSN  
Chief Executive Officer  
Saint Luke's Central Region



**TONY LUETKEMEYER**  
34TH DISTRICT

STATE CAPITOL, ROOM 430  
JEFFERSON CITY, MISSOURI 65101  
PHONE: 573-751-2183  
FAX: 573-526-9851  
TONY.LUETKEMEYER@SENATE.MO.GOV

**MISSOURI SENATE**  
JEFFERSON CITY

**COMMITTEES:**  
JUDICIARY AND CIVIL AND CRIMINAL  
JURISPRUDENCE, CHAIR  
APPROPRIATIONS  
GUBERNATORIAL APPOINTMENTS  
GOVERNMENTAL ACCOUNTABILITY AND  
FISCAL OVERSIGHT  
RULES, JOINT RULES, RESOLUTIONS AND  
ETHICS

June 27, 2024

Tim Van Zandt  
Vice President, Government & Community Relations  
Saint Luke's Health System  
Via email: [tcvanzandt@saint-lukes.org](mailto:tcvanzandt@saint-lukes.org)

Dear Mr. Van Zandt:

I understand that Saint Luke's Health System will relocate a linear accelerator to its hospital campus on Barry Road in Kansas City's Northland. Please convey my support for this straight-forward project to the Missouri Health Facilities Review Committee.

For many years Saint Luke's and Liberty Hospital have jointly operated this machine near Liberty's campus. Soon, Liberty Hospital will realign its affiliations and become part of The University of Kansas Health System. Both Saint Luke's and Liberty have agreed that Saint Luke's should assume control of the joint venture operating the linear accelerator. Naturally, both parties have motivation to relocate the machine—Liberty desires to reclaim the space occupied by the machine and Saint Luke's will achieve efficiencies by placing the unit within an existing vault on its campus.

This project would not need CON review if the only change was ownership. However, since the best course of action involves moving the machine, resulting in a new address, the technical letter of the law asks that they file for review. Which they are doing.

I ask that the committee recognize the simplicity of this and approve the relocation.

Sincerely,

Tony Luetkemeyer  
State Senator  
34<sup>th</sup> District

**CAPITOL OFFICE**  
State Capitol, Room 135-BB  
201 West Capitol Avenue  
Jefferson City, MO 65101-6806  
Tele: (573) 751-2199  
E-Mail:  
Eric.Woods@house.mo.gov



**COMMITTEES**  
**Member:**  
Agriculture Policy  
Elections and Elected Officials  
Transportation Infrastructure  
Conservation and Natural Resources

**MISSOURI HOUSE OF REPRESENTATIVES**  
**Eric Woods**  
State Representative  
District 18

June 26, 2024

Tim Van Zandt  
Vice President, Government & Community Relations  
Saint Luke's Health System  
Via email: [tcvanzandt@saint-lukes.org](mailto:tcvanzandt@saint-lukes.org)

Dear Mr. Van Zandt:

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This project would not need CON review if the only change was ownership. However, since the best course of action involves moving the machine, resulting in a new address, the technical letter of the law asks that they file for review. Which they are doing.

I ask that the committee recognize the simplicity of this and approve the relocation.

Sincerely,

A handwritten signature in black ink that reads "Eric Woods".

Eric Woods  
State Representative  
18th District

**CAPITOL OFFICE**  
State Capitol Rm 109E  
201 West Capitol Avenue  
Jefferson City, MO 65101-6806  
Tele: (573) 751-3618  
ashley.aune@house.mo.gov



**COMMITTEES**  
Emerging Issues, Ranking Member  
Ex Officio, All Committees

**MISSOURI HOUSE OF REPRESENTATIVES**

**Ashley Aune**

Minority Whip  
District 14

June 27th, 2024

Tim Van Zandt  
Vice President, Government & Community Relations  
Saint Luke's Health System  
Via email: [tcvanzandt@saint-lukes.org](mailto:tcvanzandt@saint-lukes.org)

Dear Mr. Van Zandt:

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It is my understanding this project would not need a Certificate of Need review if the only change was ownership. However, since the best course of action involves moving the machine, resulting in a new address, the technical letter of the law requires they file for review, which they are doing.

I ask that the committee recognize the simplicity of this request and approve the relocation.

Best Wishes,

A handwritten signature in black ink that reads "Ashley Aune". The signature is written in a cursive, flowing style.

Representative Ashley Aune