

**From:** [Gordon Glaus](#)  
**To:** [CONP CONP](#); [Fick, Mackinze](#); [Dorge, Alison](#)  
**Cc:** [legal](#); [Liz Glastetter](#)  
**Subject:** #6191 HT Saint Francis Medical Center Certificate of Need Application Supplemental Documentation  
**Date:** Monday, March 24, 2025 12:27:48 PM  
**Attachments:** [image001.png](#)  
[SFMC CON 6191 HT Amended Proposed Project Budget.pdf](#)  
[First Amended Cost Detail Sheet 03-21-25.pdf](#)  
[SFMC Service Area - CON 6191 HT - 03-21-25.pdf](#)

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Good afternoon,

Please find attached hereto the following supplemental materials to be added to the #6191 HT Saint Francis Medical Center Certificate of Need Application ("Saint Francis Medical Center to Replace Existing Linear Accelerators"):

1. SFMC's amended Form 1863 Proposed Project Budget with amended detail sheet with documentation of costs; and
2. SFMC's Service Area Map.

Please add these supplemental materials to SFMC's existing application. SFMC will make payment arrangements to satisfy the additional \$1,000 this afternoon, Monday, March 24, 2025. Thank you for your time and to this matter. Please let me know if there are any questions or concerns.

Sincerely,

**Gordon L. Glaus, JD**  
Staff Attorney  
Department of Legal Services  
[gglaus@sfmc.net](mailto:gglaus@sfmc.net)  
P 573-331-3491

**Saint Francis Healthcare System**  
211 Saint Francis Drive  
Cape Girardeau, MO 63703



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**From:** [Fick, Mackinze](#)  
**To:** [Gordon Glaus](#)  
**Subject:** CON 6191  
**Date:** Tuesday, March 18, 2025 12:05:00 PM  
**Attachments:** [image001.png](#)

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Gordon,

After review of your application some additional information is needed.

- Provide a service area for the staff analysis.
- How will the project be finance? Complete section 13-16 on the proposed project budget.
- It appears the trade in discount was deducted. Provide a new proposed project budget and the additional fee (\$1,000).

**This information is needed by Wednesday, March 26<sup>th</sup>, 2025.**



*Mackinze Fick*

Assistant Program Coordinator

Certificate of Need Agency :

<http://health.mo.gov/information/boards/certificateofneed/index.php>

Missouri Department of Health and Senior Services

920 Wildwood Drive, Jefferson City, MO. 65102

✉: [mackinze.fick@health.mo.gov](mailto:mackinze.fick@health.mo.gov) | ☎: 573-751-6403

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## 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 ***  | _____          |
| <b>3. Subtotal Construction Costs</b> (#1 plus #2)                 | <b>_____</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>_____</b>   |
| <b>12. Total Project Development Costs</b> (#3 plus #11)           | <b>_____**</b> |

#### **FINANCING:**

- |   |                |
|---|----------------|
| 13. Unrestricted Funds                                      | _____          |
| 14. Bonds   | _____          |
| 15. Loans   | _____          |
| 16. Other Methods (specify)                                 | _____          |
| <b>17. Total Project Financing</b> (sum of #13 through #16) | <b>_____**</b> |

- |  |       |
|--|-------|
| 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.

First Amended  
Cost Detail Sheet

<b>Costs of Project</b>	
<u>Renovations:</u>	<u>Amount:</u>
Kiefner Bros. Inc. - from quote	\$ 358,000.00
KT Power Systems - from quote	\$ 113,000.00
	\$ 471,000.00
<u>Architectural/Engineering:</u>	
Tchoukaleff Kelly Hartke - from quote	\$ 90,400.00
	\$ 90,400.00
<u>Major Medical Equipment</u>	
TrueBeam Base System 120 MLC <u>and</u> EDGE	
Base System HD120 MLC	\$ 8,562,011.00
<b>Project Total</b>	<b>\$ 9,123,411.00</b>

## Service Area Map

