Certificate of Need Program

NEW OR ADDITIONAL EQUIPMENT APPLICATION

Applicant's Completeness Checklist and Table of Contents

Project Name: CoxHealth- Acquire two additional DaVinci surgical robots Project No: 6201 HS

Project Description: Acquire two additional DaVinci surgical robots

Done	Page	N/A	Description
			Divider I. Application Summary:
✔	pg. 3		1. Applicant Identification and Certification (Form MO 580-1861)
✔	pg. 4-7		2. Representative Registration (From MO 580-1869)
✔	pg. 8-13		3. Proposed Project Budget (Form MO 580-1863) and detail sheet with documentation of costs.
			Divider II. Proposal Description:
✔	pg 15		1. Provide a complete detailed project description and include equipment bid quotes.
✔	pg 15		2. Provide a timeline of events for the project, from CON issuance through project completion.
✔	pg 15		3. Provide a legible city or county map showing the exact location of the project.
✔	pg 16		4. Define the community to be served and provide the geographic service area for the equipment.
✔	pg 16		5. Provide other statistics to document the size and validity of any user-defined geographic service area.
✔	pg 16		6. Identify specific community problems or unmet needs the proposal would address.
	pg 17		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.
✔	pg 17		8. Provide the methods and assumptions used to project utilization.
✔	pg 18		9. Document that consumer needs and preferences have been included in planning this project and describe how consumers had an opportunity to provide input.
✔	pg 19-21		10. Provide copies of any petitions, letters of support or opposition received.
✔	pg 22		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.
✔	pg 22-23		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.
✔	pg 25		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:
✔	pg 27		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.
	pg 28-30		2. Provide Service-Specific Revenues and Expenses (Form MO 580-1865) projected through three (3) **FULL** years beyond project completion.
	pg 31		3. Document how patient charges are derived.
✔	pg 32-34		4. Document responsiveness to the needs of the medically indigent.

Divider I
Application Summary

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
CoxHealth- Acquire addition DaVinci robots	6201 HS
Project Address *(Street/City/State/Zip Code)*	**County**
3801 S National, Springfield, Mo 65087	Greene

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
Lester E. Cox Medical Centers	1423 N Jefferson Ave, Springfield, Mo 65802	417-269-3108

List All Operator(s): *(List entity to be licensed or certified.)*	Address (Street/City/State/Zip Code)	Telephone Number
Lester E. Cox Medical Centers	1423 N Jefferson Ave, Springfield, Mo 65802	417-269-3108

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.)*

Name of Contact Person		Title
John Chastain		VP of Finance and Revenue Cycle
Telephone Number	**Fax Number**	**E-mail Address**
417-269-3108	417-269-3104	John.chastain@coxhealth.com
Signature of Contact Person		**Date of Signature**
		4/17/25

Certificate of Need Program

REPRESENTATIVE REGISTRATION

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

Project Name	Number
CoxHealth- Acquire addition DaVinci robots	6201 HS

(Please type or print legibly.)

Name of Representative	Title
John Chastain	VP of Finance and Revenue Cycle

Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other)	Telephone Number
CoxHealth	417-269-3108

Address (Street/City/State/Zip Code)

3801 S National, Springfield, Mo 65087

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
Lester E. Cox Medical Centers	417-269-3108

Address (Street/City/State/Zip Code)

1423 N Jefferson Ave, Springfield, Mo 65802

Check one. Do you:

- ☑ Support
- ☐ Oppose
- ☐ Neutral

Relationship to Project:

- ☐ None
- ☑ Employee
- ☐ Legal Counsel
- ☐ Consultant
- ☐ Lobbyist
- ☐ 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
	4/17/25

MO 580-1869 (11/01)

Certificate of Need Program

REPRESENTATIVE REGISTRATION

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

Project Name	Number
CoxHealth- Acquire addition DaVinci robots	6201 HS

(Please type or print legibly.)

Name of Representative	Title
Ashley Casad	SVP- President Springfield Hospital

Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other)	Telephone Number
CoxHealth	417-269-3108

Address (Street/City/State/Zip Code)

3801 S National, Springfield, Mo 65087

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
Lester E. Cox Medical Centers	417-269-3108

Address (Street/City/State/Zip Code)

1423 N Jefferson Ave, Springfield, Mo 65802

Check one. Do you:

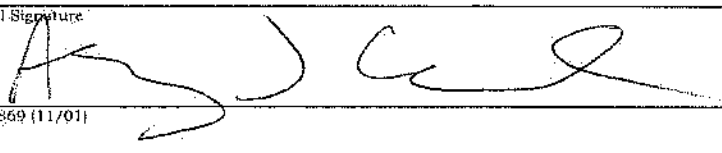
- ☑ Support
- ☐ Oppose
- ☐ Neutral

Relationship to Project:

- ☐ None
- ☑ Employee
- ☐ Legal Counsel
- ☐ Consultant
- ☐ Lobbyist
- ☐ 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
	4/22/25

MO 580-1869 (11/01)

Certificate of Need Program

REPRESENTATIVE REGISTRATION

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

Project Name	Number
CoxHealth- Acquire addition DaVinci robots	6201 HS

(Please type or print legibly.)

Name of Representative	Title
Katelyn Knox	Director of Finance

Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other)	Telephone Number
CoxHealth	417-269-3108

Address (Street/City/State/Zip Code)

3801 S National, Springfield, Mo 65087

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
Lester E. Cox Medical Centers	417-269-3108

Address (Street/City/State/Zip Code)

1423 N Jefferson Ave, Springfield, Mo 65802

Check one. Do you:

- ☑ Support
- ☐ Oppose
- ☐ Neutral

Relationship to Project:

- ☐ None
- ☑ Employee
- ☐ Legal Counsel
- ☐ Consultant
- ☐ Lobbyist
- ☐ 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
Katelyn Knox	04/17/25

Certificate of Need Program

REPRESENTATIVE REGISTRATION

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

Project Name	Number
CoxHealth- Acquire addition DaVinci robots	6201 HS

(Please type or print legibly.)

Name of Representative	Title
Tina Lehr	VP of Operations

Firm/Corporation/Association of Representative (may be different from below, e.g., law firm, consultant, other)	Telephone Number
CoxHealth	417-269-3108

Address (Street/City/State/Zip Code)

3801 S National, Springfield, Mo 65087

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
Lester E. Cox Medical Centers	417-269-3108

Address (Street/City/State/Zip Code)

1423 N Jefferson Ave, Springfield, Mo 65802

Check one. Do you:

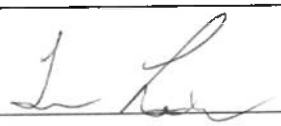
- [x] Support
- [ ] Oppose
- [ ] Neutral

Relationship to Project:

- [ ] None
- [x] Employee
- [ ] Legal Counsel
- [ ] Consultant
- [ ] Lobbyist
- [ ] 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
	4-29-2025

Certificate of Need Program

PROPOSED PROJECT BUDGET

Description	**Dollars**
COSTS:*	*(Fill in every line, even if the amount is "$0".)*
1. New Construction Costs ***	$0
2. Renovation Costs ***	$0
3. Subtotal Construction Costs (#1 plus #2)	$0
4. Architectural/Engineering Fees	$0
5. Other Equipment (not in construction contract)	$0
6. Major Medical Equipment	$5,047,000
7. Land Acquisition Costs ***	$0
8. Consultants' Fees/Legal Fees ***	$0
9. Interest During Construction (net of interest earned) ***	$0
10. Other Costs ***	$0
11. Subtotal Non-Construction Costs (sum of #4 through #10	$5,047,000
12. Total Project Development Costs (#3 plus #11)	$5,047,000 **
FINANCING:	
13. Unrestricted Funds	$5,047,000
14. Bonds	$0
15. Loans	$0
16. Other Methods (specify)	$0
17. Total Project Financing (sum of #13 through #16)	$5,047,000 **
18. New Construction Total Square Footage	0
19. New Construction Costs Per Square Foot *****	$0
20. Renovated Space Total Square Footage	0
21. Renovated Space Costs Per Square Foot ******	$0

* *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.*

INTUITIVE

Intuitive Surgical, Inc.
1020 Kifer Road
Sunnyvale, CA 94086
800-876-1310

Quote Details

Quote ID	Q-00080229
Quote Date	4/22/2025
Valid Until	06/30/2025
Sales Rep	Nick Purcell
Phone Number	+1-314-495-2080
Email	nick.purcell@intusurg.com

Company Information

Hospital Name	Cox Medical Centers-South
SF ID/IDN Affiliation	13446/CoxHealth
Address	3801 S National Ave
City, State, Zip	Springfield, Missouri, 65807
Contact Name	
Telephone	

Please submit orders electronically via GHX or fax to 408-523-2377

Part Number	Qty	Item	Price	Subtotal
Systems				
	1	Da Vinci 5 Single Console System (Fluorescence Imaging Included): One (1): da Vinci 5® System Console One (1): Integrated Simulator One (1): da Vinci 5® System Tower One (1): Integrated Intuitive HUB One (1): Integrated Insufflator One (1): Integrated E-200 Generator One (1): CO2 Tank Kit One (1): da Vinci 5® System Patient Cart One (1): da Vinci 5® Operating System Software Package (including Integrated table motion) Vision Equipment Accessories Training Instruments da Vinci 5 ® System Documentation	$ 2,500,000.00	$ 2,500,000.00
	1	Da Vinci 5 Single Console System (Fluorescence Imaging Included): One (1): da Vinci 5® System Console One (1): Integrated Simulator One (1): da Vinci 5® System Tower One (1): Integrated Intuitive HUB One (1): Integrated Insufflator One (1): Integrated E-200 Generator One (1): CO2 Tank Kit One (1): da Vinci 5® System Patient Cart One (1): da Vinci 5® Operating System Software Package (including Integrated table motion) Vision Equipment Accessories Training Instruments da Vinci 5 ® System Documentation	$ 2,500,000.00	$ 2,500,000.00
Upgrades				
	1	Da Vinci E-200 Generator (Backup)	$ 25,000.00	$ 25,000.00
Freight				
	1	System Freight - Central (AR, IA, IL, KS, LA, MN, MO, ND, NE, OK, SD, TX, WI)	$ 11,000.00	$ 11,000.00
	1	System Freight - Central (AR, IA, IL, KS, LA, MN, MO, ND, NE, OK, SD,	$ 11,000.00	$ 11,000.00

		TX, WI)		
Total				**$ 5,047,000.00**

Part Number	Months	Item	Price	Annual Service Fee
Service				
	12	da Vinci 5-Single Console-Human Use (Systems)-SERVICE PLAN : DVCOMPLETE CARE-Warranty (Included)	$ 0.00	$ 0.00
	48	da Vinci 5-Single Console-Human Use (Systems)-SERVICE PLAN : DVCOMPLETE CARE-After Warranty Service (Annual)	$ 195,000.00	$ 195,000.00
	12	SERVICE PLAN : E-200 BACKUP-Warranty (Included)	$ 0.00	$ 0.00
	48	SERVICE PLAN : E-200 BACKUP-After Warranty Service (Annual)	$ 0.00	$ 0.00
	12	da Vinci 5-Single Console-Human Use (Systems)-SERVICE PLAN : DVCOMPLETE CARE-Warranty (Included)	$ 0.00	$ 0.00
	48	da Vinci 5-Single Console-Human Use (Systems)-SERVICE PLAN : DVCOMPLETE CARE-After Warranty Service (Annual)	$ 195,000.00	$ 195,000.00
Subscription				
	12	MY INTUITIVE+ SUBSCRIPTION-Subscription (Included)	$ 0.00	$ 0.00
	*	MY INTUITIVE+ SUBSCRIPTION-Subscription Fee-(Annually Recurring)	$ 70,000.00	$ 70,000.00
	12	MY INTUITIVE+ SUBSCRIPTION-Subscription (Included)	$ 0.00	$ 0.00
	*	MY INTUITIVE+ SUBSCRIPTION-Subscription Fee-(Annually Recurring)	$ 70,000.00	$ 70,000.00

Terms and Conditions

1) Terms and Conditions

1.1 A signed Sales, License, and Service Agreement ("SLSA") or equivalent is required prior to shipment of the System(s) or System Upgrades. All site modifications and preparation are the Customer's responsibility and are to be completed to the specification given by Intuitive Surgical, Inc. ("Intuitive") prior to the installation date.

1.2 Customer acknowledges that the cleaning and sterilization equipment, not provided by Intuitive, is required to appropriately reprocess da Vinci® instruments and endoscopes. Please refer to the Intuitive Surgical Reprocessing website: https://reprocessing.intuitivesurgical.com. Customer is responsible for ensuring that its' cleaning and sterilization program comply with all health and safety requirements.

2) REQUIREMENTS PRIOR TO SHIPMENT

2.1 System delivery is subject to credit approval **and** receipt of Customer's purchase order by Intuitive. Whether or not Customer issues a purchase order does not affect Customer's commitment to acquire and pay for the System.

Please provide the following for shipment and billing reference:

- Purchase Order No: _____
- Point of Contact: _____
- Email: _____
- Phone Number: _____

3) I&A Terms and Conditions:

3.1 To place an order, please fax Purchase Order to Intuitive Surgical Customer Service at 408-523-2377 or submit through the Global Health Exchange (GHX). Payment Terms are Net 30 days from invoice date. Delivery is subject to credit approval by Intuitive Surgical. Estimated 2-Day standard delivery. Standard shipping terms are FCA from Intuitive's warehouse and are subject to inventory availability. All taxes and shipping charges are the responsibility of the Customer and will be added to the invoice, as appropriate. Pricing is subject to change without notice. A $9.95 handling charge will be applied for any shipments using Customer's designated carrier.

4) Return Goods Policy:

4.1 All returns must be authorized through Intuitive Surgical Customer Service, please call 800-876-1310 to obtain a Return Material Authorization Number (RMA#). All items must be accompanied with valid RMA# for processing and are requested to be received within 14 days of issuance, or the RMA could be subject to cancellation. Intuitive Surgical will prepay for the return of the defective

instruments. Upon identification of a defective instrument, please call Intuitive Surgical Customer Service within 5 business days. Prior to returning to Intuitive Surgical, items must be cleaned and decontaminated in accordance with the then current local environmental and safety laws and standards. For all excess inventory returns, items are required to be in the original packaging with no markings, seals intact, and to have been purchased within the last 12 months. Package excess returned inventory in a separate shipping container to prevent damage to original product packaging.

5) Exchange Goods Policy:

5.1 Repairs to Endoscope, Camera Head and Skills Simulators may qualify for Intuitive Surgical advanced exchange program. Please contact Customer Service or send email to CustomerSupport-ServiceSupport@intusurg.com to obtain information on our current exchange program.

6) Credit Policy:

6.1 Intuitive will issue credit against the original purchase order after full inspection is complete. Credit for defective returns: Intuitive will issue credit on products based on failure analysis performed and individual warranty terms. For instruments, credit will be issued for the remaining lives, plus one additional life to compensate for usage at the time the issue was identified. Evidence of negligence, misuse and mishandling will not qualify for credit. Credit for excess inventory returns: Excess Inventory returns will be valued at the invoice price. Original packaging must be unmarked, undamaged and seals intact to qualify for credit. Credit will be issued if the products were shipped less than 12 months prior to return request, the original package is intact, and the product is within expiration date. Intuitive will retain all returned products.

7) Miscellaneous:

7.1 Warranty: Warranties are applied for manufacturing defects.

- Endoscope, Camera, Simulator, Systems and System upgrades – 1 year warranty.
- Accessories – 90-day warranty.
- Instruments: see above for credit.

7.2 Any term or condition contained in your purchase order or similar forms which is different from, inconsistent with, or in addition to these terms shall be void and of no effect unless agreed to in writing and signed by your authorized representative and authorized representative of Intuitive Surgical. The terms and conditions of this quote, including pricing, are confidential and proprietary information of Intuitive Surgical and shall not be disclosed to any third party without the consent of Intuitive Surgical. For questions, please contact Customer Service at 800-876-1310.

EXHIBIT A
Deliverables, Price and Delivery

da Vinci 5® Single Console System (Firefly® Fluorescence Imaging Enabled)

One (1): da Vinci 5® System Console
One (1): Integrated Simulator
One (1): da Vinci 5® System Tower
One (1): Integrated Intuitive HUB
- One (1): Integrated Insufflator
- One (1): Integrated E-200 Generator
- One (1): CO2 Tank Kit

One (1): da Vinci 5® System Patient Cart
One (1): da Vinci 5® Operating System Software Package (including Integrated Table Motion)
- Warranty period: One (1) year from the Acceptance

Vision Equipment:
- One (1): NIR Handheld Camera Control Unit
- One (1): NIR Handheld Camera Light Source
- One (1): NIR Handheld Camera
- Two (2): da Vinci 5® Endoscope, 0°
- Two (2): da Vinci 5® Endoscope, 30°
- Four (4): da Vinci 5® Endoscope Trays
- One (1) NIR Handheld Reprocessing Tray
  - Warranty period: One (1) year from the Acceptance

Accessories:
- One (1): Box of 10: Tip Cover Accessory (For use with Endowrist Monopolar Curved Scissors)
- Three (3): Monopolar Cautery Cord
- Three (3): Bipolar Cautery Cord
- Eight (8): 8 mm Hex Cannula, standard
- Two (2): Box of 6: 8 mm Bladeless Obturator
- Four (4): Box of 10: Universal Seal (5-12mm)
- One (1): Box of 3: 8mm Gage Pin
- Two (2): Pack of 20: Instrument Arm Drape
- One (1): Pack of 20: Column Drape
- Three (3): 8mm Instrument Introducer
- Two (2): 12mm Stapler Cannula
- Two (2): Box of 6: Da Vinci Insufflator Tube Set - Smoke Evacuation
- One (1) NIR Handheld Camera Light Guide
- One (1): Light Guide Adapter for Schoelly and Storz endoscopes
- One (1): Laparoscope 10mm, 0°, NIR
- One (1): Laparoscope 10mm, 30°, NIR
- One (1): Laparoscope 5mm, 0°
- One (1): Laparoscope 5mm, 30°
  - Warranty period: 90 days from Acceptance

Training Instruments
- One (1): Monopolar Curved Scissors, Training
- One (1): Force Bipolar, Training
- One (1): Large Needle Driver, Training
- One (1): Mega SutureCut Needle Driver, Training
- One (1): Cadiere Forceps, Training
  - Warranty period: 90 days from Acceptance

da Vinci 5® System Documentation

One (1): da Vinci 5 System User Manual
One (1): E-200 User Manual
One (1): Insufflator/Tube Set User Manual
One (1): Force Feedback User Manual
One (1): Integrated table Motion, Quick Reference Guide: Bedside
One (1): Integrated Table Motion, Quick Reference Guide: Anesthesia
One (1): Reprocessing Wall Chart Kit
One (1): Cleaning and Sterilization Kit
One (1): US Language Kit
One (1): Da Vinci 5 Representative Adult Uses System User Manual Addendum
One (1): Da Vinci 5 SynchroSeal Instruments and Accessories User Manual Addendum
One (1): SureForm 45 and SureForm 60 Instruments and Accessories User Manual Addendum
One (1): SureForm 45 and SureForm 60 Force Fire, FDA Guidance
One (1): NIR Camera System User Manual Addendum
One (1): Universal Reprocessing Hardware kit
Two (2): Endowrist Instrument Release Kit (IRK)
Warranty period: n/a

Upgrades with Incremental Costs:
One (1): Backup E-200 Kit (plus service)
Warranty period: One (1) year from the Acceptance

(all kits subject to change without notice)

Divider II
Proposal Description

Divider II Proposal Description:

1. **Provide a complete detailed project description and include equipment bid quotes.**

This Certificate of Need application is for the purchase of two new DaVinci Xi Surgical System robots at our Springfield location. The volume of DaVinci robotic surgeries has grown significantly in recent years as CoxHealth has continued to add new surgeons to the system. In FY25, we added 16 new robotic surgeons in Springfield, with an additional 3 robotic surgeons planned in FY26. We currently have 5 DaVinci Robots in Springfield, which are being used by colorectal, general surgery, gynecology, orthopedics, pulmonology, urology specialties. While our surgical volumes are increasing, there is reduced access per surgeon due to the limited time blocks available. We plan to acquire two additional DaVinci robots to help provide more surgical blocks.

The quote for the equipment was included above in Divider I- total equipment costs of $5,047,000.

2. Provide a timeline of events for the project, from CON issuance through project completed.

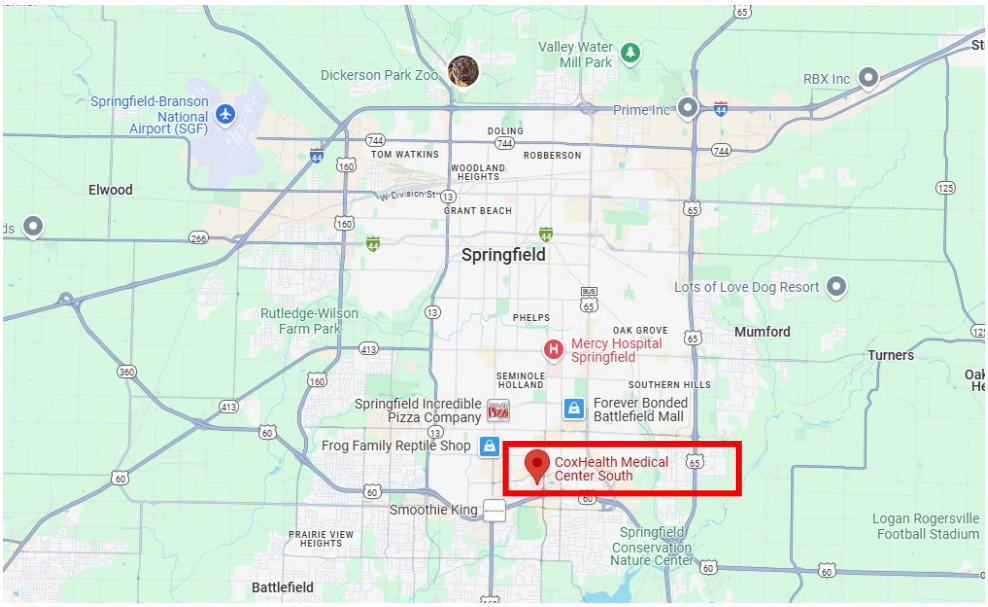
CON Application submission- 05/01/2025

CON Committee approval- 07/14/2025

DaVinci robot placement- 09/02/2025

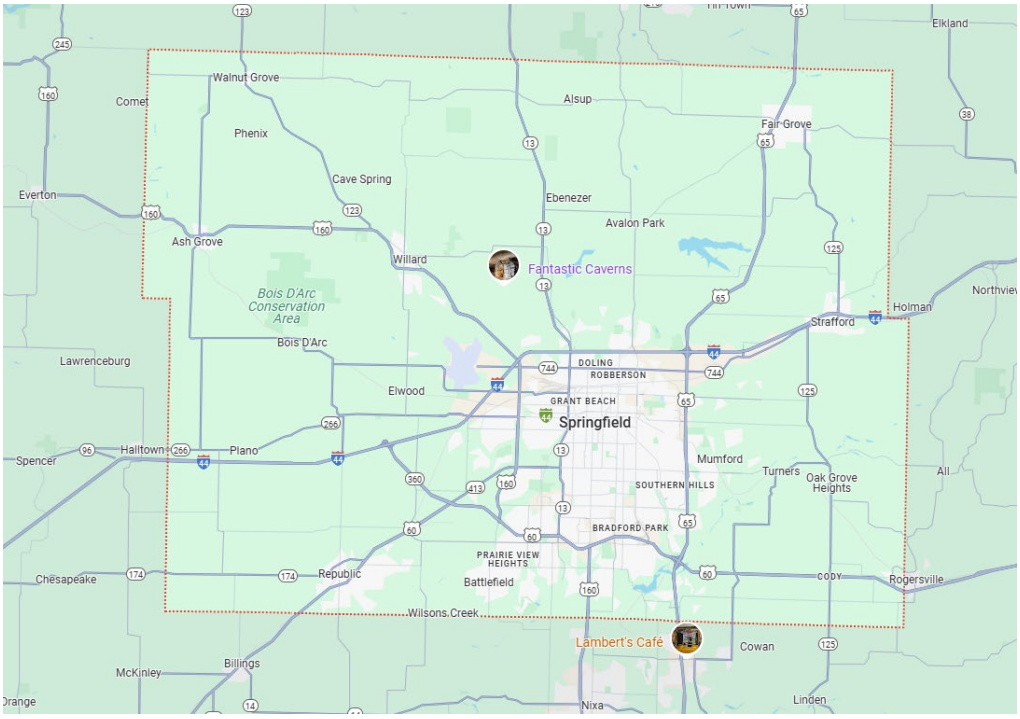
3. Provide a legible city or county map showing the exact location of the project.

Map below shows city of Springfield with location for CoxHealth Medical Center South



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

The primary service area will be Greene County- see map below.



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

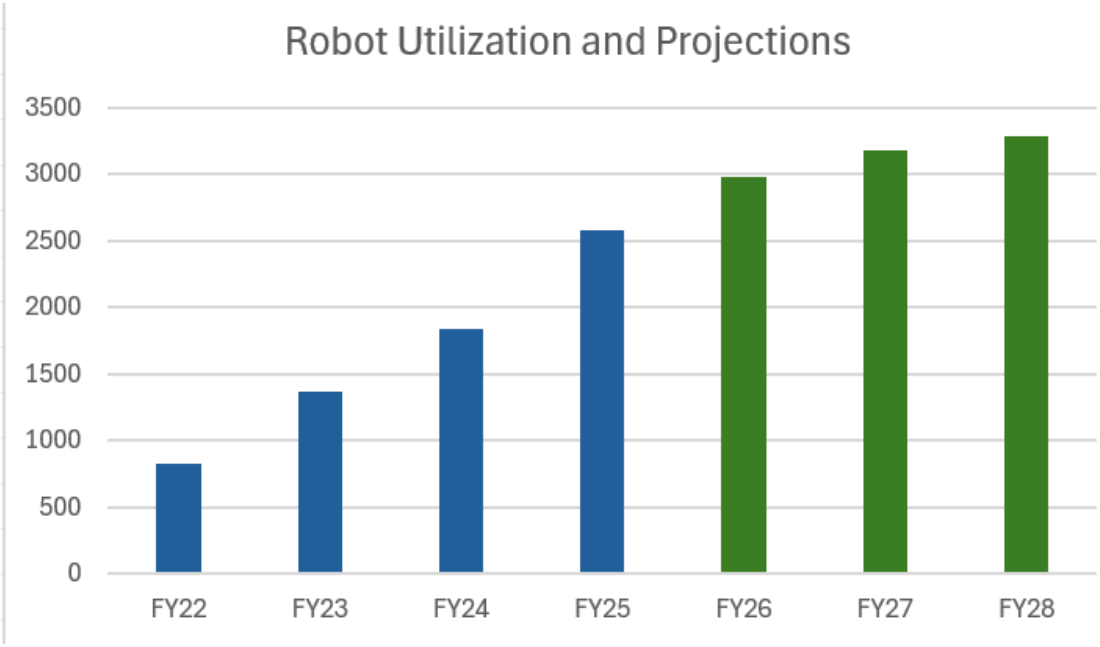
The projected Greene County population for 2030 is 318,574.

For FY24 (Oct 2023- Sept 2024), CoxHealth's Springfield hospitals had 37,519 admissions and 33,352 surgical cases – 8,035 inpatient and 25,317 outpatient.

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

The volumes of surgical cases are increasing. The purchase of the two robots will increase access to robotic surgeries, which will help us reach more patients and improve the health of our community.

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.



Key-
Blue- Actual
Green- Projections

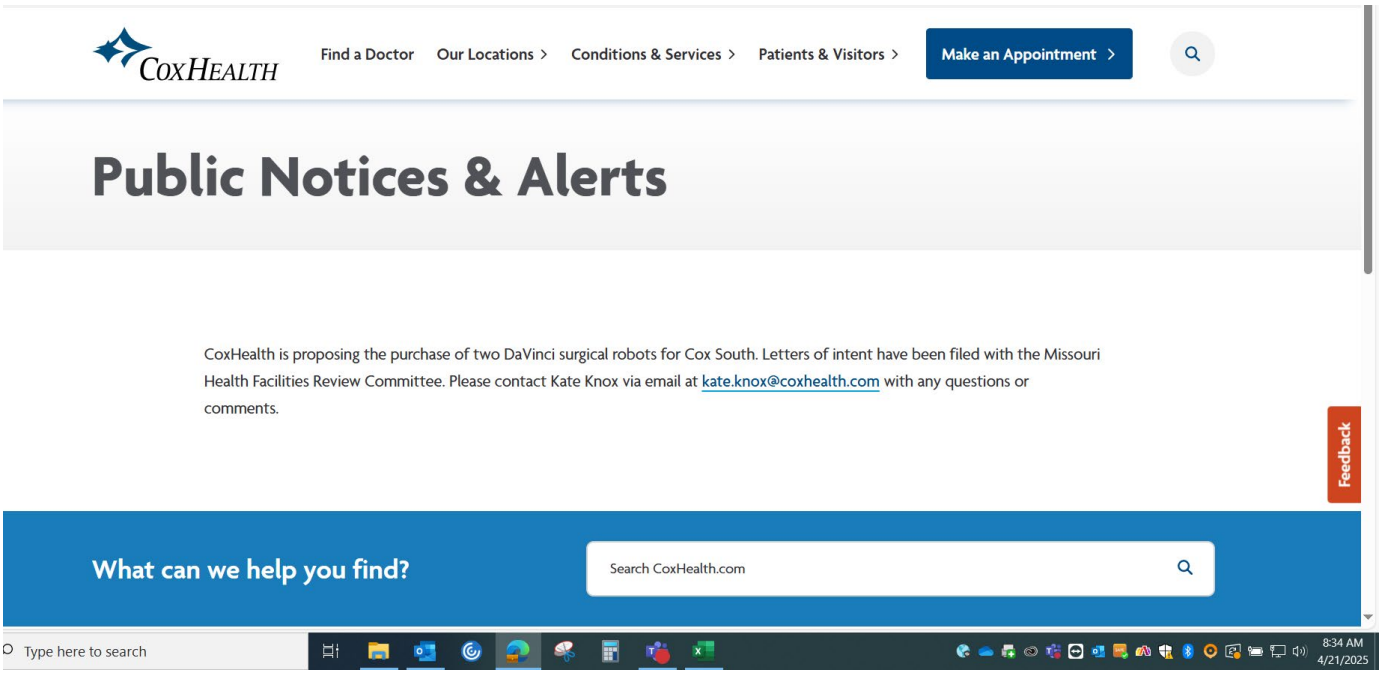
NOTE: FY24 Q4 reflects an additional robot, FY25 reflects additional robotic surgeons to CoxHealth, and FY26 reflects the increase of 2 additional robots.

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

Total utilization based on historical volume and estimated increase due to the addition of new providers starting this year and the additional surgical blocks per robot.

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

Public notice was added to CoxHealth's website with contact information for anyone with questions or concerns.



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

See the following support letters below:

Amanda Hedgpeth, Executive Vice President and Chief Operating Officer

Dr. Shawn Ussery, Senior Vice President and Chief Medical Officer

Dr. Randy Mullins, Medical Director- Procedure Service Line

CoxHealth

April 25, 2025

Missouri Health Facilities Review Committee
920 Wildwood Drive
Jefferson City, Missouri 65804

To Whom It May Concern,

I have been made aware of the Certificate of Need application by CoxHealth in Springfield for the acquisition of two additional DaVinci robot surgical systems. I understand that the DaVinci robotic system is not new technology, has been in use since 2000 and has FDA approval. The acquisition of the additional DaVinci systems will allow us to be better serve our patients by improving the health of the communities we serve.

I support CoxHealth's application for the additional DaVinci surgical systems.

Thank you,

Amanda Hedgpeth

Amanda Hedgpeth
Executive Vice President and Chief Operating Officer

CoxHealth

April 25, 2025

Missouri Health Facilities Review Committee
920 Wildwood Drive
Jefferson City, Missouri 65804

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Thank you,

Dr. Shawn Usery
Senior Vice President and Chief Medical Officer

CoxHealth

April 25, 2025

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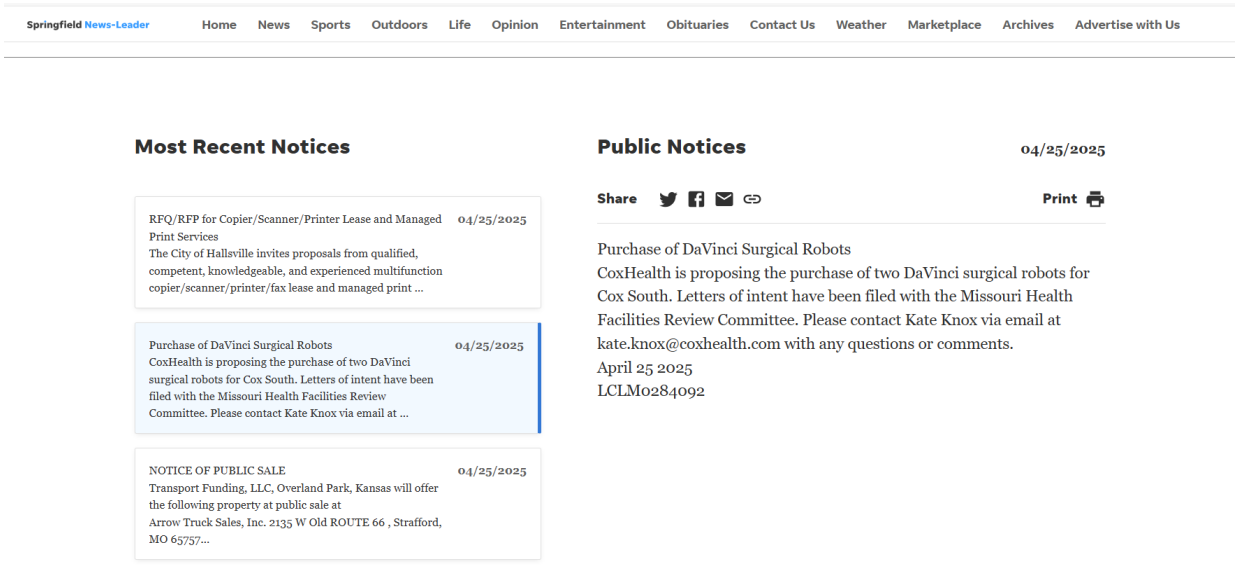
I support CoxHealth's application for the additional DaVinci surgical systems.

Thank you,

Dr. Randy Mullins
Medical Director- Procedure Service Line

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.



Springfield News-Leader Home News Sports Outdoors Life Opinion Entertainment Obituaries Contact Us Weather Marketplace Archives Advertise with Us

Most Recent Notices

RFQ/RFP for Copier/Scanner/Printer Lease and Managed Print Services 04/25/2025
The City of Hallsville invites proposals from qualified, competent, knowledgeable, and experienced multifunction copier/scanner/printer/fax lease and managed print ...

Purchase of DaVinci Surgical Robots 04/25/2025
CoxHealth is proposing the purchase of two DaVinci surgical robots for Cox South. Letters of intent have been filed with the Missouri Health Facilities Review Committee. Please contact Kate Knox via email at ...

NOTICE OF PUBLIC SALE 04/25/2025
Transport Funding, LLC, Overland Park, Kansas will offer the following property at public sale at Arrow Truck Sales, Inc. 2135 W Old ROUTE 66 , Strafford, MO 65757...

Public Notices 04/25/2025

Share Print

Purchase of DaVinci Surgical Robots
CoxHealth is proposing the purchase of two DaVinci surgical robots for Cox South. Letters of intent have been filed with the Missouri Health Facilities Review Committee. Please contact Kate Knox via email at kate.knox@coxhealth.com with any questions or comments.
April 25 2025
LCLM0284092

12. Document that providers of all affected facilities in the proposed service area were addressed letters regarding the application.

See letter to Mercy- Springfield Communities below.

CoxHealth

April 23, 2025

John Myers
Mercy Springfield Communities
1235 E Cherokee Street
Springfield, Missouri 65804

Mr. Myers,

CoxHealth is applying to the Missouri Health Facilities Review Committee for two additional DaVinci surgical robots for our Cox South Springfield location. State regulation requires hospital facilities in the service area to be notified directly.

If you have questions or concerns about implementation of the project, please contact john.chastain@coxhealth.com or at 417-269-3108.

Thank you,

John Chastain
VP of Finance and Revenue Cycle

Divider III
Service Specific Criteria and Standards

Divider III Service Specific Criteria and Standards:

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

We currently have 5 DaVinci robots in Springfield as of Q3 FY24. As of Q2 FY25, we performed 629 robotic surgeries for South OR, which exceeds the community need rates of 240 robotic surgeries.

Robot Volumes by System

FY	FY22		FY23				FY24				FY25	
Location	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Branson OR								**2**	**86**	**131**	**175**	**157**
Xi (SK7683)								2	86	131	175	157
MOC OR		**26**	**107**	**110**	**93**	**111**	**134**	**140**	**142**	**134**	**124**	**177**
Mako (Ortho)		26	107	110	93	111	134	140	142	134	124	177
South Endo			**10**	**18**	**25**	**29**	**40**	**37**	**37**	**39**	**44**	**40**
Ion (EN0793)			10	18	25	29	40	37	37	39	44	40
South OR	**276**	**285**	**325**	**299**	**374**	**365**	**441**	**412**	**420**	**562**	**662**	**629**
Xi (RSK8118)	94	107	128	103	128	122	136	130	121	133	144	132
Xi (SK2120)	17	11	21	14	42	50	60	63	74	88	116	103
Xi (SK5352)	80	66	65	74	90	76	96	93	92	98	113	105
Xi (SK5354)	85	101	111	108	114	117	149	126	128	147	158	147
Xi (SK7843)									5	96	131	142
Grand Total	**276**	**311**	**442**	**427**	**492**	**505**	**615**	**591**	**685**	**866**	**1005**	**1003**

Divider IV
Financial Feasibility Criteria and Standards

Commerce Trust
Banking | Investments | Planning

April 25, 2025

Missouri Health Facilities Review Committee
920 Wildwood Drive
Jefferson City, Missouri 65804

To Whom It May Concern:

The purpose of this communication is to advise you that CoxHealth has maintained a banking relationship with Commerce Bank for many years and has consistently maintained liquidity and capital reserves sufficient to support a capital expenditure of $5,047,000.

Please do not hesitate to give me a call at 417.837.5264 if you have any questions or if I can be of additional assistance.

Thank you,

J. Duke Harshberger
Vice President
Commerce Trust Company

CC: Jake McWay, CFO CoxHealth

Certificate of Need Program

SERVICE-SPECIFIC REVENUES AND EXPENSES

Project Title: CoxHealth- Acquire additional DaVinci Robots **Project #:** 6201 HS

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 2022	Year 2023	Year 2024
Amount of Utilization:*	831	1,362	1,839
Revenue:			
Average Charge**	$61,924	$63,205	$64,509
Gross Revenue	$51,458,844	$86,085,210	$118,632,051
Revenue Deductions	41,403,958	69,252,162	95,056,628
Operating Revenue	10,054,886	16,833,048	23,575,423
Other Revenue	0	0	0
TOTAL REVENUE	**$10,054,886**	**$16,833,048**	**$23,575,423**
Expenses:			
Direct Expenses			
Salaries	3,293,936	3,197,454	4,326,986
Fees	0	0	0
Supplies	1,474,600	1,896,855	3,589,328
Other	5,314,967	7,297,840	8,252,932
TOTAL DIRECT	$10,083,503	$12,392,149	$16,169,246
Indirect Expenses			
Depreciation	0	0	0
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	4,793,973	5,212,451	7,307,775
TOTAL INDIRECT	$4,793,973	$5,212,451	$7,307,775
TOTAL EXPENSES	**$14,877,476**	**$17,604,600**	**$23,477,021**
NET INCOME (LOSS):	**-$4,822,590**	**-$771,552**	**$98,402**

*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: Acquire Additional DaVinci Robots **Project #:** 6201 HS

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 2025	Year 2026	Year 2027
Amount of Utilization:*	2,582	2,982	3,182
Revenue:			
Average Charge**	$65,799	$67,115	$68,457
Gross Revenue	$169,893,018	$200,136,930	$217,830,174
Revenue Deductions	137,832,111	162,641,891	177,279,661
Operating Revenue	32,060,907	37,495,039	40,550,513
Other Revenue	0	0	0
TOTAL REVENUE	**$32,060,907**	**$37,495,039**	**$40,550,513**
Expenses:			
Direct Expenses			
Salaries	6,431,762	7,428,162	7,926,362
Fees	0	0	0
Supplies	4,554,545	5,260,129	5,612,921
Other	12,711,186	14,680,386	15,664,986
TOTAL DIRECT	$23,697,493	$27,368,677	$29,204,269
Indirect Expenses			
Depreciation	0	0	0
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	6,412,274	7,499,105	8,110,400
TOTAL INDIRECT	$6,412,274	$7,499,105	$8,110,400
TOTAL EXPENSES	**$30,109,767**	**$34,867,782**	**$37,314,669**
NET INCOME (LOSS):	**$1,951,140**	**$2,627,257**	**$3,235,844**

*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: Acquire Additional DaVinci Robots **Project #:** 6201 HS

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		
	2028		
Amount of Utilization:*	3,282		
Revenue:			
Average Charge**	$69,827		
Gross Revenue	$229,172,214	$0	$0
Revenue Deductions	186,143,644		
Operating Revenue	43,028,570	0	0
Other Revenue	0		0
TOTAL REVENUE	**$43,028,570**	**$0**	**$0**
Expenses:			
Direct Expenses			
Salaries	8,175,462		
Fees	0	0	0
Supplies	5,789,317		
Other	16,157,286		
TOTAL DIRECT	$30,122,065	$0	$0
Indirect Expenses			
Depreciation	0	0	0
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	8,605,462		
TOTAL INDIRECT	$8,605,462	$0	$0
TOTAL EXPENSES	**$38,727,527**	**$0**	**$0**
NET INCOME (LOSS):	**$4,301,043**	**$0**	**$0**

*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.

Divider IV Financial Feasibility Review Criteria and Standards:

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

   Patient charges are derived by accumulating all the cost of services, including labor and supplies, utilized during the robotic procedure. Therefore, the charges are specific to the patient's needs.

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

   See financial assistance policy below.

COXHEALTH

SYSTEM POLICY – Finance

TITLE: Financial Assistance Policy (FAP)

SUBMITTED BY: Dana Christiansen, Administrative Director - Patient Access Services
APPROVED BY: John Chastain, VP of Finance and Revenue Cycle

PURPOSE:

The purpose of CoxHealth's Financial Assistance Policy (FAP) is intended solely for the benefit of Indigent patients and any acceptable Guarantors for debts incurred due to Emergency Services and Medically Necessary Services. The FAP is not to be construed to benefit third parties such as insurance companies or others who are obligated for a patient's health care expenses. The FAP is also meant to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder and shall be interpreted and applied in accordance with such regulations. The FAP has been adopted by the governing body of CoxHealth in accordance with the regulations under Section 501(r).

SCOPE:

The FAP and any corresponding procedures apply to all CoxHealth hospitals and physician clinics set forth on **Schedule 3** of the FAP (collectively "CoxHealth").

POLICY:

CoxHealth wants to help patients who do not have health insurance or who need help paying their hospital bills. As a nonprofit health care organization, CoxHealth cares about our patients and the communities we serve through better health and better health care.

Our staff can help you with the following:

- Apply for health insurance through the Marketplace
- Apply for Medicaid assistance or Disability
- Determine if you qualify for Financial Assistance from CoxHealth

CoxHealth Financial Assistance

First and foremost, a patient's financial circumstances will not affect their care. All patients are treated with respect and fairness. Patients who meet certain income guidelines may qualify for CoxHealth Financial Assistance, including reduced hospital charges and payment plans.

Subject to the attached **Schedule 1,** patients who are eligible for Financial Assistance will be billed not more than the amounts generally billed to individuals who have insurance covering such care. Information regarding amounts generally billed and its calculation is available on the attached **Schedule 1**, by speaking with a Financial Counselor or by calling the numbers below.

Financial Assistance approval will be in effect for 6 months from the date of approval. Exceptions to the Financial Assistance qualification criteria will be considered on an individual basis.

Medical Qualifications for Financial Assistance

CoxHealth will provide, without exception, care for emergency medical conditions to all patients seeking such care, regardless of ability to pay or to qualify for Financial Assistance, in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Financial Assistance is available only for emergency and medically necessary services. It does not apply to elective procedures such as cosmetic surgery. It also does not apply to the portion of your services that have been paid for by a third party such as an insurance company or government program.

Income Guidelines for Financial Assistance

The amount of Financial Assistance you receive is based on Federal Poverty Level information set by the U.S. government each year. A Financial Assistance Income and Discount Schedule that shows these income levels is attached on **Schedule 2**. In addition to your income, the discount will also take into account the size of your family.

A list of providers who are included in this Policy is attached as **Schedule 3**. Other services which are separately billed by other providers, such as independent physicians, are not eligible under CoxHealth's Financial Assistance Policy. For a full listing of these providers, please see the attached **Schedule 4**. These lists are also available by using the information below.

Applying for Financial Assistance

Patients or their legal guardian may apply for Financial Assistance at any time – before, during or after care, up to 240 days after initial bill. Information is provided with the bill about how to apply for assistance. An application is also available on the attached **Schedule 5**, available on the coxhealth.com website, upon request at CoxHealth facilities, including, but not limited to, emergency rooms and admissions/registration areas, or by calling the numbers below and requesting a copy. The application requires proof of income such as an income tax return or paycheck stub. Examples of documents which may be used as proof of income can be found on the application form.

Patients who are uninsured or eligible/enrolled in Medicaid automatically qualify for Financial Assistance for emergency and medically necessary hospital services that are not covered by Medicaid. Patients may also be approved for additional Financial Assistance based on the patient's financial and/or socio-economic position. Eligibility for this type of assistance does not automatically qualify the patient for assistance on future accounts.

Completed applications may be mailed to:

CoxHealth

Attn: Financial Counselors
PO Box 650
Branson, Mo. 65615

Completed Applications may be faxed to:

Fax 417-335-7071

Completed applications may be returned in person (not mailed) to any Cox Outpatient registration or Cox Emergency Department in Springfield, Branson, Monett, Lamar, or at the following locations:

Cox Medical Center South West Pavilion Entrance 3801 S. National Ave. Springfield, MO **Cox Primrose Building** Patient Financial Services 1115 E Primrose St. Springfield, Mo. West side under awning	**Cox Medical Center Branson** Medical Plaza One 101 Skaggs Rd Branson, MO Business Office/ 2nd floor **CoxHealth Monett** 1000 US-60 Monett, MO Outpatient Registration **Cox Barton County Hospital** 29 NW 1st Lane Lamar, MO Outpatient Registration

Or by email to: FinancialAssistanceApplications@CoxHealth.com