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
Mercy Hosptial St. Francis	6204 HS
Project Address *(Street/City/State/Zip Code)*	**County**
100 US-60 Mountain View, MO 65548	Howell

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
Mercy Hospital St. Francis	100 US-60 Mountain View, MO 65548	417-934-7000

List All Operator(s): *(List entity to be licensed or certified.)*	Address (Street/City/State/Zip Code)	Telephone Number
Mercy Hospital-St. Francis	100 US-60 Mountain View, MO 65548	417-934-7000

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
William J. Roberts		Chief Financial Officer
Telephone Number	**Fax Number**	**E-mail Address**
417-820-7363	417-820-2103	William.Roberts@Mercy.net
Signature of Contact Person		**Date of Signature**
		04/21/2025