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*