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 competition.
__	_____	__	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.

MO 580-2503 (03/20)

Certificate of Need Program

EXPEDITED LTC BED REPLACEMENT/EXPANSION 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 (Form 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 the issuance of the CON through project completion.
3. Provide preliminary schematic drawings for the proposed project.
4. Provide the existing and proposed gross square footage.
5. Document ownership of the project site.

Divider III. Community Need Criteria and Standards:

1. If the proposal is to relocate RCF/ALF beds within 6-mile radius in accordance with §197.318.4(4) provide the following:
   - Documentation that all facilities involved are under the same licensure ownership or control;
   - Documentation that all facilities involved are within the 6-mile limit; and
   - Documentation that all owners and operators of the facility from which the beds are being transferred are aware of the proposal and consent to it.
2. If the proposal is to replace one-half of a qualifying licensed facility's beds within a 30-mile radius in accordance with §197.318.5 provide the following:
   - Documentation that the facility has only been operating 50% of its licensed capacity with every resident residing in a private room and all vacant beds have been reported to the Division of Regulation and Licensure as unavailable for occupancy for at least the most recent four consecutive calendar quarters;
   - Documentation that the replacement beds shall be built to private room specifications and only used for single occupancy; and
   - Documentation that the existing and proposed facilities have the same owner or owners, and that the owner or owners stipulate that the beds to be replaced shall not be used later for long term care; if the existing facility is being operated under a lease, both the lessee and owner shall stipulate the same.
3. If the proposal is to replace a facility in its entirety at a single site within a 15-mile radius in accordance with §197.318.6 provide the following:
   - Documentation that all facilities involved are within the 15-mile limit; and
   - Documentation that the existing facility and the proposed facility have the same owner or owners with a written stipulation that the facility to be replaced will not be used later for a long term care.
4. If the proposal is to expand under provisions of §197.318.4(1) and the effort to purchase has been successful provide:
   - Purchase Agreement Form(s) (MO 580-2352); and
   - A copy of the selling facility's reissued license verifying surrender of beds sold.
5. If the proposal is to expand under provisions of §197.318.4(1) and effort(s) to purchase have been unsuccessful, provide Purchase Agreement Form(s) (MO 580-2352) verifying unsuccessful effort(s) to purchase.

Certificate of Need Program

EXPEDITED LTC RENOVATION/MODERNIZATION 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 (Form 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 the issuance of the CON through project completion.

☐ ___ ☐ 3. Provide preliminary schematic drawings for the proposed project.

☐ ___ ☐ 4. Provide the existing and proposed gross square footage.

☐ ___ ☐ 5. Document ownership of the project site.

Divider III. Community Need Criteria and Standards:

☐ ___ ☐ 1. Indicate whether the proposed project is needed to comply with current facility code requirements of local, state or federal governments.

☐ ___ ☐ 2. Indicate whether the proposed project is needed to meet requirements for licensure, certification or accreditation, which if not undertaken, could result in a loss of accreditation or certification.

☐ ___ ☐ 3. Describe any operational efficiencies to be attained through reconfiguration of space and functions.

☐ ___ ☐ 4. Describe the methodologies used for determining need.

☐ ___ ☐ 5. Provide the rationale for the reallocation of space and functions.

MO 580-2505 (02/13)

Certificate of Need Program

EQUIPMENT REPLACEMENT 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, CON project number of the existing equipment (if prev. CON approved), and include the type/brand of both the existing equipment and the replacement equipment.
			2. Provide a listing with itemized costs of the medical equipment to be acquired and bid quotes.
			3. Provide a timeline of events for the project, from CON issuance through project completion.
			Divider III. Service Specific Criteria and Standards:
			1. Describe the financial rationale for the proposed replacement equipment.
			2. Document if the existing equipment has exceeded its useful life.
			3. Describe the effect the replacement unit would have on quality of care.
			4. Document if the existing equipment is in constant need of repair.
			5. Document if the lease on the current unit has expired.
			6. Describe the technological advances provided by the new unit.
			7. Describe how patient satisfaction would be improved.
			8. Describe how patient outcomes would be improved.
			9. Describe what impact the new unit would have on utilization.
			10. Describe any new capabilities that the new unit would provide.
			11. By what percent will this replacement increase patient charges.

(If replacement equipment was not previously approved, also complete Divider IV below.)

			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.

AUTHORITY: section 197.320, RSMo 2016. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.440 Criteria and Standards for Equipment and New Hospitals. The committee is amending sections (1) and (2) and subsection (4)(B).

PURPOSE: The committee is amending this rule to remove need methodologies for new major medical units, add three (3) full years of utilization data for new/additional units, add robotic surgery utilization requirements, and add three (3) full years of data for new hospital projects.

(1) For new units or services in the service area, use the following *[methodologies]*:

[(A) The population-based need formula is (Unmet need = (R × P)—U) where:
P = Year 2025 population in the service area(s). use population in 19 CSR 60-50.430;
U = Number of service units in the service area(s); and
R = Community need rate of one (1) unit per population listed as follows:

1. Magnetic resonance imaging unit: 28,000
2. Positron emission tomography/computed tomography unit: 224,000
3. Lithotripsy unit: 486,000
4. Linear accelerator unit: 78,000
5. Cardiac catheterization lab: 42,000
6. Gamma knife: 1,947,000
7. Computed tomography: 15,000]

*[(B)]***(A) Provide** *[T]***t**he minimum annual utilization for *[all]* **each of the** other providers in the service area **for the most recent three (3) full years, if applicable. The provider(s)** should achieve at least the following community need rates as follows **by the final year**:

1. Magnetic resonance imaging procedures: 2,000
2. Positron emission tomography/computed tomography procedures: 1,000
3. Lithotripsy treatments: 1,000
4. Linear accelerator treatments: 3,500
5. Cardiac catheterization procedures (include coronary angioplasties): 500
6. Gamma knife treatments: 200
7. Computed tomography: 3,500
8. **Robotic surgery system: 240**

*[(C)]***(B)** For long-term care hospitals (such as a hospital-within-a-hospital or long-term acute care hospital), the applicant should comply with the standards as described in 42 CFR, section 412.23(e), and the bed need should meet the applicable population-based bed need methodology in 19 CSR 60-50.450;

*[(D)]***(C)** Alternate methodologies may also be provided.

(2) For additional units or services, **provide** the applicant's *[optimal]* annual utilization **for the most recent three (3) full years, if applicable. The applicant** should achieve at least the following community need rates as follows**, by the final year**:

(A) Magnetic resonance imaging procedures: 3,000
(B) Positron emission tomography/computed tomography procedures: 1,000
(C) Lithotripsy treatments: 1,000
(D) Linear accelerator treatments: 6,000
(E) Cardiac catheterization procedures: 750
(F) Gamma knife treatments: 200
(G) Computed tomography: 4,000
(H) Robotic surgery system: 240

(4) For the construction of a new hospital, the following questions shall be answered:

(B) Provide **the most recent three (3) full years of** evidence that the *[current]* **average** occupancy of **the same type(s) of beds at each** other hospital*[s]* in the proposed service area exceeds eighty percent (80%).

AUTHORITY: section 197.320, RSMo 2016. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.450 Criteria and Standards for Long-Term Care. The committee is amending subsections (1)(D), (3)(A), (3)(B) and section (6), deleting sections (5) and (7), and renumbering the remaining sections accordingly.

PURPOSE: The committee is amending this rule to remove verbiage related to a demonstration project that is no longer effective, word

updates, and to include a CON form within the rule rather than incorporating it by reference.

(1) The following population-based long-term care bed need methodology for the fifteen- (15-)*[-]* mile radius shall be used to determine the need:

(D) If the project is to add beds to an existing long-term care facility, the applicant shall state whether or not the facility received any *[patient]* **resident** care Class I deficiencies within the last eighteen (18) months as a result of a survey, inspection**,** or complaint investigation and the reason for and status of the deficiencies.

(3) A**n** LTC bed expansion involving a Chapter 198 facility may qualify for shortened information requirements and review time frames. The applicant shall submit the following information:

(A) If an effort to purchase has been successful pursuant to section 197.318.4(1), RSMo, a Purchase Agreement (Form MO 580-2352)**, included herein,** between the selling and purchasing facilities, and a copy of the selling facility's reissued license verifying the surrender of the beds sold; or

(B) If an effort to purchase has been unsuccessful pursuant to section 197.318.4(1), RSMo, a Purchase Agreement (Form MO 580-2352)**, included herein,** between the selling and purchasing facilities which documents the "effort(s) to purchase" LTC beds.

[(5) Any newly-licensed Chapter 198 facility established as a result of the Alzheimer's and dementia demonstration projects pursuant to Chapter 198, RSMo, or aging-in-place pilot projects pursuant to Chapter 198, RSMo, as implemented by the Division of Regulation and Licensure (DRL), may be licensed by the DRL until the completion of each project. If a demonstration or pilot project receives a successful evaluation from the DRL and a qualified Missouri school or university, and meets the DRL standards for licensure, this will ensure continued licensure without a new CON.]

*[(6)]***(5)** For LTC renovation or modernization projects which do not include increasing the number of beds, the applicant shall document the following, if applicable:

(A) The proposed project is needed to comply with current facility code local, state, or federal government requirements for licensure, certification, or accreditation;

(B) Operational efficiencies will be attained through reconfiguration of space and functions;

(C) The methodologies used for determining need and the reallocation of space and functions; and

(D) The benefits to the facility because of its age or condition.

[(7) The following form cited in this rule is incorporated by reference and published by the Certificate of Need Program (CONP), May 1, 2012, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a written request to CONP@health.mo.gov, or acquired in person at the CONP Office, 3418 Knipp Drive, Suite F, Jefferson City, Missouri, 65102 (573) 751-6403. This rule does not include any later amendments or additions.

(A) Purchase Agreement (Form MO 580-2352).]

Certificate of Need Program

PURCHASE AGREEMENT

Part 1: Purchasing Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____

Number/Type of Licensed Beds: _____ ☐ RCF/ALF ☐ ICF/SNF (Check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility.)

Owner(s): _____

Operator(s): _____

Part II: Selling Facility Information

Name of Facility: _____

Address (no PO Box): _____

City, State, Zip, County: _____ _____ _____ _____

Number/Type Licensed Beds: _____ ☐ RCF/ALF ☐ ICF/SNF (Check RCF/ALF for residential care and assisted living facility or ICF/SNF for intermediate care and skilled nursing facility.)

Owner(s): _____

Operator(s): _____

Part III: Value of Consideration

Monetary Value of Purchase: $_____ No./Type Beds:_____

Terms of Purchase: _____

(Add more pages as necessary to describe the sale.)

Part IV: Certification of Information

☐ Yes ☐ No The above Purchaser and Seller have agreed to these purchase terms.

Purchaser Signature: _____

Title/Date: _____ _____

Seller(s) Signature(s):

Owner(s):_____

Operator(s):_____

Title/Date: _____ _____

MO 580-2352 (05/12)

AUTHORITY: section 197.320, RSMo 2016. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.470 Criteria and Standards for Financial Feasibility. The committee is amending section (1) and subsection (3)(A), and deleting section (7).

PURPOSE: The committee is amending this rule to include certain CON forms within the rule rather than incorporating them by reference.

(1) Proposals for any new hospital, skilled nursing facility, intermediate care facility, residential care facility, or assisted living facility construction must include documentation that the proposed costs per square foot are reasonable when compared to the latest RS Means Cost Data Percentile Limit Total New Construction Project Costs (Form MO 580-1866)**, included herein,** available from the Certificate of Need Program (CONP). Any proposal with costs in excess of the three-fourths (3/4) percentile must include justification for the higher costs.

(3) Document financial feasibility by including—

(A) The Service-Specific Revenues and Expenses (Form MO 580-1865)**, included herein,** as a financial pro forma for each revenue generating service affected by the project for the past three (3) full years projected through three (3) full years beyond project completion; and

[(7) The following forms cited in this rule are incorporated by reference and published by the Certificate of Need Program (CONP), October 1, 2009, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a written request to CONP@health.mo.gov , or acquired in person at the CONP Office, 3418 Knipp Drive, Suite F, Jefferson City, Missouri, 65102 (573) 751-6403. This rule does not include any later amendments or additions.

(A) Service-Specific Revenues and Expenses (Form MO 580-1865).

(B) RS Means Cost Data (Form MO 580-1866).]

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 20??	Year 20??	Year 20??
Amount of Utilization:*	0	0	0
Revenue:			
Average Charge**	$0	$0	$0
Gross Revenue	$0	$0	$0
Revenue Deductions	0	0	0
Operating Revenue	0	0	0
Other Revenue	0	0	0
TOTAL REVENUE	**$0**	**$0**	**$0**
Expenses:			
Direct Expenses			
Salaries	0	0	0
Fees	0	0	0
Supplies	0	0	0
Other	0	0	0
TOTAL DIRECT	$0	$0	$0
Indirect Expenses			
Depreciation	0	0	0
Interest***	0	0	0
Rent/Lease	0	0	0
Overhead****	0	0	0
TOTAL INDIRECT	$0	$0	$0
TOTAL EXPENSES	**$0**	**$0**	**$0**
NET INCOME (LOSS):	**$0**	**$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.

MO 580-1865 (08/06)

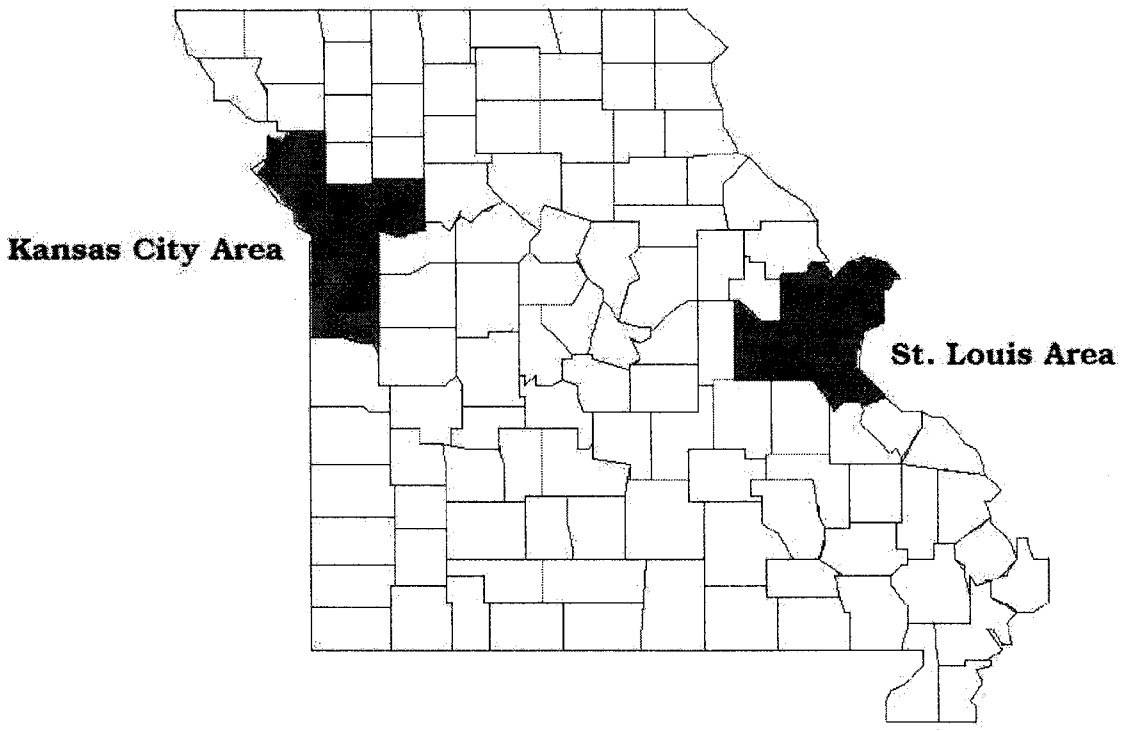
RS Means Cost Data

RS Means Cost Data Percentile Limits
Total New Construction Project Costs*

Source: 2022 RS Means Building Construction Cost Data

Type of Facility	Percentile	St. Louis Area	Kansas City Area	Other Missouri Area
Hospital	**3/4**	460.92	454.09	419.97
Cost Per Sq. Ft.	Median	430.53	424.15	392.28
Nursing Home/	**3/4**	219.82	216.57	200.29
Assisted Living Facility**	Median	182.34	179.64	166.14
Cost Per Sq. Ft.				

***Since 2017, nursing homes and assisted living facilities have been combined into one cost per square foot.*



*** Renovation costs should not exceed 70% of total new construction project costs.**

MO 580-1866

AUTHORITY: section 197.320, RSMo 2016. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.500 Additional Information. The committee is amending section (3).

PURPOSE: The committee is amending this rule to provide submission deadlines of information by affected parties.

(3) *[Information submitted by affected persons shall be received at the committee's principal office at least five (5) calendar days before the scheduled meeting of the committee]* **Support, neutral, and opposing information submitted by affected persons shall be received at the committee's principal office three (3) business days before the scheduled meeting of the committee**.

AUTHORITY: section 197.320, RSMo 2016. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.700 Post-Decision Activity. The committee is amending sections (1) and (2) and subsections (4)(A) and (7)(B), adding new sections (8)-(11), deleting section (9), and renumbering as needed.

PURPOSE: The committee is amending this rule to define what is acceptable for aboveground construction, add budget requirements for cost overrun requests, add owner, operator, and site change requirements, and add Applicant Identification form.

(1) Applicants who have been granted a Certificate of Need (CON) or a Non-Applicability CON letter shall file reports by mail or email with the Missouri Health Facilities Review Committee (committee), using Periodic Progress Report (Form MO 580-1871)**, included herein**. A report shall be filed within ten (10) days following the end of each six**-** (6**-**)*[-]* month period after CON approval, or issuance of a Non-Applicability CON letter, until the project is complete which includes the licensing of all new beds, installation of equipment**,** and/or completion of renovations. All Periodic Progress Reports must contain a complete and accurate accounting of all expenditures for the report period. Final project costs with third-party verification must be provided on a Periodic Progress Report (Form MO 580-1871)**, included herein**.

(2) Applicants who have been granted a CON and fail to incur a capital expenditure within six (6) months may request an extension of six (6) months by submitting a written request to the committee outlining the reasons for the failure, with a listing of the actions to be taken within the requested extension period to insure compliance. The Certificate of Need Program (CONP) staff on behalf of the committee will analyze the request and grant an extension, if appropriate. Applicants may request additional extensions by submitting a completed Request for Extension (Form MO 580-1872)**, included herein**, and must provide financial information plus other documentation describing delays.

(4) A CON shall be subject to forfeiture for failure to—

(A) Incur a project-specific capital expenditure within twelve (12) months after the date the CON was issued through initiation of project aboveground construction **by any of the following: installation of structural support; installation of structural steel; installation of framing; establishing foundations and a wall** or lease/purchase of the proposed equipment since a capital expenditure, according to generally accepted accounting principles, must be applied to a capital asset; or

(7) Cost overrun review procedures implement the CON statute section 197.315.7, RSMo. Immediately upon discovery that a project's actual costs would exceed approved project costs by more than ten percent (10%), the applicant shall apply for approval of the cost variance. A nonrefundable fee in the amount of one-tenth of one percent (0.1%) of the additional project cost above the approved amount made payable to "Missouri Health Facilities Review Committee" shall be required. The information requirements for a cost overrun review are required as follows:

(B) Provide a Proposed Project Budget (Form MO 580-1863)**, included herein, and budget detail including all methods and assumptions used. Documentation of costs may be requested**.

(8) Applicants may request a project owner change. The information requirements for an owner change review are as follows:

(A) Reason for owner change;

(B) Statement as to whether or not the proposed owner is an affiliate of the current owner, and explanation of relationship;

(C) Evidence that the existing owner agrees to the change. This can be a statement or a contract;

(D) Documentation that the proposed owner owns the site, or has an executed option to purchase or lease the real property;

(E) Documentation that the proposed owner(s) is registered to do business in Missouri;

(F) Documentation that sufficient financing would be available to assure completion of the project;

(G) Provide a complete and signed Applicant Identification and Certification (Form MO 580-1861), included herein, with the proposed owner listed.

(9) Applicants may request a project operator change. The information requirements for an operator change review are as follows:

(A) Reason for operator change;

(B) Statement as to whether or not the proposed operator is an affiliate of the current operator, and explanation of relationship;

(C) Evidence that the existing operator agrees to the change. This can be a statement or a contract;

(D) Documentation that the proposed operator(s) is registered to do business in Missouri;

(E) The proposed operator must provide a brief explanation of their ability and experience operating a long-term care facility;

1. State if the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years;

2. If the license of the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years, provide the name and address of the facility whose license was revoked;

3. State if the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years; and

4. If the Medicare and/or Medicaid certification of any facility owned or operated by the proposed operator or any affiliate of the proposed operator has been revoked within the previous five (5) years, provide the name and address of the facility whose Medicare and/or Medicaid certification was revoked; and

(F) Provide a complete and signed Applicant Identification and Certification (Form MO 580-1861), included herein, with the proposed operator listed.

(10) Applicants may request a project site change. The information requirements for a site change review are as follows:

(A) Reason for site change;

(B) Documentation the proposed site is within fifteen (15) miles as the crow flies of the existing site;

(C) Documentation that the owner owns the site, or has an executed option to purchase or lease the real property;

(D) Documentation of the cost of the proposed site;

(E) A legible street or road map showing the exact location of the facility or health service, and a copy of the site plan showing the relation of the project to existing structures and boundaries;

(F) Statement as to whether or not the project cost would change. If the project cost would change, submit a revised proposed budget and fee if applicable;

(G) Provide the population-based long-term care bed need methodology for the fifteen- (15-) mile radius of the proposed site;

(H) Provide a complete and signed Applicant Identification and Certification (Form MO 580-1861), included herein, with the proposed site listed;

(I) List of any additional changes to the project as originally presented to the committee, such as—

1. Decrease in the number of beds. If a decrease, how many beds would be licensed;

2. Change to the building structure(s). If there would be a change, a description of the change(s), the total square footage, and revised schematics of the proposed building(s) with all use of space marked; and

3. The timeline of events for the project, from site change approval through project completion;

(J) Statement of how consumers were made aware of the proposed site change. All feedback received from consumers regarding the proposed site; and

(K) Documentation that sufficient financing would be available to assure completion of the project.

(11) Any applicant who requests an owner, operator or site change or cost overrun must still comply with sections (1) and (2) of this rule.

*[(8)]***(12)** At any time during the process from Letter of Intent to project completion, the applicant is responsible for notifying the committee of any change in the designated contact person. If a change is necessary, the applicant must file a Contact Person Correction (Form MO 580-1870)**, included herein**.

[(9) The following forms cited in this rule are incorporated by reference and published by the Certificate of Need Program (CONP), December 13, 2019, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a written request to CONP@health.mo.gov, or acquire in person at the CONP Office, 3418 Knipp Drive, Suite F, Jefferson City, Missouri, 65102 (573) 751-6403. This rule does not include any later amendments or additions.

(A) Periodic Progress Report (Form MO 580-1871).

(B) Extension Request (Form MO 580-1872).

(C) Proposed Project Budget (Form MO 580-1863).

(D) Contact Person Correction (Form MO 580-1870).]

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
Project Address *(Street/City/State/Zip Code)*	County

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

List All Operator(s): *(List entity to be licensed or certified.)*	Address (Street/City/State/Zip Code)	Telephone Number

3. Ownership *(Check applicable category.)*

☐ Nonprofit Corporation	Δ Individual	Δ City	Δ District
☐ Partnership	Δ Corporation	Δ County	Δ 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
Telephone Number	Fax Number	E-mail Address
Signature of Contact Person		Date of Signature

MO 580-1861 (03/13)

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 ***	
3. **Subtotal Construction Costs** (#1 plus #2)	$0
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 ***	
11. **Subtotal Non-Construction Costs** (sum of #4 through #10	$0
12. **Total Project Development Costs** (#3 plus #11)	$0**
FINANCING:	
13. Unrestricted Funds	
14. Bonds	
15. Loans	
16. Other Methods (specify)	
17. **Total Project Financing** (sum of #13 through #16)	$0**
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.*

MO 580-1863 (02/13)

Certificate of Need Program

CONTACT PERSON CORRECTION

Project Name:	**Project Number:**

Please type or print legibly the current "Contact Person" information below:

Contact Person *(Name/Association)*	**Title**
Telephone Number	**E-mail Address**

Please type or print legibly the corrected "Contact Person" information below:

Contact Person *(Name/Association)*		**Title**
Address *(Street/City/State/Zip Code)*		
Telephone Number	**Fax Number**	**E-mail Address**
Corrected Contact Person (*Signature Required*)		**Date**
Applicant *(Print or Type Name)*		
Applicant *(Signature Required)*		**Date**

MO 580-1870 (08/06)

Certificate of Need Program

PERIODIC PROGRESS REPORT

Instructions for Completion (see attached blank forms)

Purpose: To gather uniform data regarding the progress and compliance of approved Certificate of Need (CON) projects in accordance with §197.300 to §197.366 RSMo; and to provide data to develop, implement and manage a database for project tracking, monitoring, notification and follow-up.

Used by: Missouri Health Facilities Review Committee, CON Program Staff, and Project Contact Person.

General: Periodic Progress Reports (PPRs) must provide all requested data and information in a complete, concise and legible manner. Each PPR must indicate if it is an Intermediate or Final Report. PPRs which are incomplete, illegible and/or contain mathematical discrepancies may be returned to the Contact Person for appropriate corrective action.

Project ID: Any changes in this information must be brought to the attention of the CON Program Staff immediately upon occurrence.

Add'l. Info.: *Additional information MUST be attached to* ***substantiate*** *answers to the individual questions. All final PPRs must include documentation which substantiates all claims and expenditures.*

Individual Questions:

1. **Have capital expenditures been incurred for the proposed construction and/or medical equipment?** A capital expenditure shall be deemed to have occurred if the applicant has at least one or more of the following:

   - **Construction expenditures** assignable to a capital asset in accordance with generally accepted accounting principles and which are not chargeble to pre-development or operating costs, which may be documented by a signed AIA construction contract with starting and ending dates; and above-ground construction;
   - **Purchase Orders (POs)** which are signed and which include the date of purchase, delivery, installation and operational date; or
   - **Acquisition** of medical equipment or property by lease, transfer, or purchase which has been authorized by the applicant and includes the date of the lease, the annual cost, cost and date of buy-out; purchase date, delivery installation and operational dates; and transfer date, current value, installation and operational date.

   If the answer to this question is "Yes," then attach copies of the appropriate signed construction contract (include pictures of construction activity), purchase order, or lease agreement (with original signatures).

   If capital expenditure or expenditure for medical equipment has not been incurred, provide a detailed explanation and include the steps being taken to correct the situation within the time constraints of §197.315.9 RSMo. Indicate the nature, costs and the date that a capital expenditure will be incurred.

2. **Are the expenditures for this reporting period/project-to-date included?**

   List all project expenditures, by category, incurred during the reported period and project-to-date on the **Project Budget/Expenditures** form.

3. **Are the projected final costs within the limits approved?** *(Self-explanatory)*

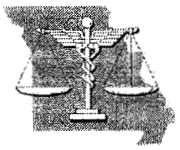
   Using current costs and expenditures, extrapolate final project costs to the project completion date. If total costs will exceed those approved by the Committee by more than 10%, specify and explain the area and category involved. Also, indicate the estimated filing date for your cost-overrun application.

4. **Are there any changes in the services or programs as approved in the application?** *(Explain any changes)*

5. **Has the project contact person changed?**
   If "Yes," enclose a new CON Contact Person Correction Form.

6. **Percentage of Construction or installation complete.**

   (If the expenditures and construction/installation are both 100% complete, provide a final report.)



Certificate of Need Program

PERIODIC PROGRESS REPORT

Type of Progress Report:
☐ Intermediate
☐ Final

All applicants granted a Certificate of Need (CON) by the Missouri Health Facilities Review Committee are required to submit periodic progress reports until such time as the project is complete (§197.315 (8) RSMo). These reports **must** be filed with the CON Program staff after the end of **each six (6) month reporting period** following the issuance of a CON.

Name of Project	Report Period
	Project Number
Address	Date CON Issued
Project Description	Approved Cost

☐ Yes ☐ No **1. Have capital expenditures been incurred for the proposed construction through aboveground construction, renovations or lease/purchase of the proposed equipment?**

_____ Date aboveground construction or renovations commenced, or equipment purchased. Provide documentation (i.e. photos, copy of AIA contract and/or purchase order).

☐ Yes ☐ No ***2. Are the expenditures for this reporting period/project to-date included?**

_____% Percent of the total approved project amount that has been expended to date.

☐ Yes ☐ No **3. Are the projected final costs within the limits approved?**

If "No" and costs are above 10% of approved amount, then submit a cost over-run application.

$_____Estimated final project cost

☐ Yes ☐ No **4. Are there any changes in the services or programs as approved in the application?**

If "Yes" explain in detail and provide replacement pages for the approved application.

☐ Yes ☐ No **5. Has the project contact person changed?**

If "Yes," enclose a new Contact Person Correction Form (MO 580-1870).

***6. Construction or installation is _____% complete.** *(Not the same as expenditures to-date.)*

If Items 2 and 6 are both 100% complete, signify this as the **Final Report and submit documentation of final costs.*

Describe the status and progress of the project to-date. Clearly explain expenditures, delays, changes in project progress, or lack of progress. *(Use additional pages as needed.)*

MO 580-1871 (08/06)

Certificate of Need Program

PERIODIC PROGRESS REPORT

Project Budget/Expenditures	Report Period:_____to_____		
Description	**Application**	**This Period**	**Project to-date**
1. General Construction Costs	0	0	0
2. Renovation Costs	0	0	0
3. Subtotal Construction Costs	**$0**	**$0**	**$0**
4. Architectural/Engineering Fees	0	0	0
5. Other Equipment (not in construction contract)	0	0	0
6. Major Medical Equipment	0	0	0
7. Land Acquisition Costs	0	0	0
8. Consultants' Fees/Legal Fees	0	0	0
9. Interest During Construction	0	0	0
10. Other Costs	0	0	0
11. Subtotal Non-construction Costs	**$0**	**$0**	**$0**
12. TOTAL Project Development Costs	**$0**	**$0**	**$0**
Square footage of New Construction	0	0	0
Square footage of Renovation	0	0	0
Total square footage for Project	0	0	0
Costs per square foot: New Construction	0	0	0
Costs per square foot: Renovation	0	0	0

Name of Contact Person	Title	
Telephone Number	Fax Number	E-mail Address

MO 580-1871 (07/09)

Certificate of Need
Request for Extension

To request a six-month extension to incur a capital expenditure or above-ground construction, complete this form in its entirety. Also submit a completed Periodic Progress Report with this form if it is due at this time. Send this information by email to CONP@health.mo.gov (preferred), fax at 573-751-7894, or mail to CONP, P.O. Box 570, Jefferson City, MO 65102. Request for extensions must be received in adequate time to allow for processing prior to the meeting for which a decision is scheduled.

Date:	
Project #:	Project Name:
Project Title/Description:	

1. Briefly explain why a capital expenditure will not be incurred by the current deadline.

2. Briefly state the reason(s) for the extension request.

3. What steps have been completed for the project to date and when were they completed?

Date Completed	**Step Completed**

4. What steps are needed in order incur a capital expenditure (above ground construction or equipment lease/purchase) for the project, and when will they be completed?

Anticipated Completion Date	**Step to be Completed**

5. What are the steps that will take place after the capital expenditure to complete the project and when do you anticipate that they will be completed?

Anticipated Completion Date	**Step to be Completed**

6. Are planning and/or zoning matters complete, and is the site approved? ☐ Yes ☐ No
   If "no", explain.

7. Has financing been secured for the project? ☐ Yes ☐ No
   If financing has been acquired and documentation was not previously provided, attach a copy of the letter from the lender or 3rd party documentation.
   Are financing contingencies complete? ☐ Yes ☐ No
   Is financing available for immediate disbursal for the project? ☐ Yes ☐ No

   If the answer is "no" to any of the above questions, explain.

   Give specifics of any and all existing financing problems and the reason(s) for their occurrence.

8. Are there any new equity partners for the project as originally presented to the committee? ☐ Yes ☐ No
   If "yes", explain.

9. Explain any and all restructuring of the project as originally presented to the committee.

10. Describe any anticipated situation(s) or problems not previously addressed that may prevent the project from incurring a capital expenditure by the end of the requested extension, should the extension be granted.

11. If this extension is granted, do you anticipate that additional six-month extensions will be necessary?
    ☐ Yes ☐ No If "yes", how many would be needed? ____
    Explain why additional extensions would be needed.

Signature	Printed Name	Date

AUTHORITY: section 197.320, RSMo 2016. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

PROPOSED AMENDMENT

19 CSR 60-50.800 Meeting Procedures. The committee is amending subsection (6)(F) and deleting section (8).

PURPOSE: The committee is amending this rule to include a CON form within the rule rather than incorporating it by reference.

(6) The committee may give the applicant and affected persons an opportunity to make brief presentations at the meeting according to the Missouri Health Facilities Review Committee Meeting Format and Missouri Health Facilities Review Committee Meeting Protocol. The applicant and affected persons shall conform to the following procedures:

(F) All presenters shall complete and sign a Representative Registration (Form MO 580-1869)**, included herein,** and give it to the sign-in coordinator prior to speaking;

[(8) The following form cited in this rule is incorporated by reference and published by the Certificate of Need Program (CONP), October 1, 2009, and may be downloaded from http://health.mo.gov/information/boards/certificateofneed/forms.php, obtained by emailing a written request to CONP@health.mo.gov, or acquired in person at the CONP Office, 3418 Knipp Drive, Suite F, Jefferson City, Missouri, 65102 (573) 751-6403. This rule does not include any later amendments or additions.

(A) Representative Registration (Form MO 580-1869).]

Certificate of Need Program

REPRESENTATIVE REGISTRATION

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

Project Name	Number

(Please type or print legibly.)

Name of Representative	Title

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

Address (Street/City/State/Zip Code)

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

Address (Street/City/State/Zip Code)

Check one. Do you:

- Δ Support
- Δ Oppose
- Δ Neutral

Relationship to Project:

- Δ None
- Δ Employee
- Δ Legal Counsel
- Δ Consultant
- Δ Lobbyist
- Δ 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

MO 580-1869 (11/01)

AUTHORITY: section 197.320, RSMo 2016. Original rule filed June 2, 1994, effective Nov. 30, 1994. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 29, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Health Facilities Review Committee, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109 or via email at CONP@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2230—State Board of Podiatric Medicine
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2230-2.010 Licensure by Examination. The board is amending subsection (2)(E).

PURPOSE: This proposed change clarifies how long score reports from the National Board of Podiatric Medical Examiners can be accepted for licensure by examination.

(2) No application will be considered until the board receives all of the following:

(E) A certified score report from the National Board of Podiatric Medical Examiners or successor thereof, certifying satisfactory completion of all parts of the National Board Examination **within the previous two (2) years**;

AUTHORITY: sections 330.010, 330.040, and 330.140, RSMo 2016. This rule originally filed as 4 CSR 230-2.010. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 22, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Podiatric Medicine, PO Box 1335, Jefferson City, MO 65102, by facsimile at (573) 751-6301, or via email at podiatry@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2233—State Committee of Marital and Family Therapists
Chapter 2—Licensure Requirements

PROPOSED AMENDMENT

20 CSR 2233-2.010 Educational Requirements. The committee is amending section (3).

PURPOSE: This amendment amends the language regarding client contact hours.

(3) An applicant for licensure or supervision shall have completed the following:

(A) Three (3) semester hours or five (5) quarter hours of study in the area of theoretical foundations of marriage and family therapy; *[and]*

(B) Twelve (12) semester hours or twenty (20) quarter hours of study in the area of the practice of marriage and family therapy; *[and]*

(C) Six (6) semester hours or ten (10) quarter hours of study in the area of human development and family studies; *[and]*

(D) Three (3) semester hours or five (5) quarter hours of study in the area of ethics and professional studies; *[and]*

(E) Three (3) semester hours or five (5) quarter hours of study in the area of research methodology; *[and]*

(F) Six (6) semester hours or ten (10) quarter hours of practicum in marital and family therapy, including *[at least five hundred (500) hours of client contact.]* **the number of client contact hours as set forth by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) standards; and**

AUTHORITY: sections 337.715[, RSMo 2016,] and [section] 337.727, RSMo Supp. [2019] ***2021****. This rule originally filed as 4 CSR 233-2.010. Original rule filed Dec. 31, 1997, effective July 30, 1998. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed June 22, 2022.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with State Committee of Marital and Family Therapists, Gloria Lindsey, Executive Director, PO Box 1335, Jefferson City, MO 65102, by faxing comments to (573) 751-0735, or by emailing comments to maritalfam@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*