# 2004 ILLINOIS REGISTER

RULES OF GOVERNMENTAL AGENCIES

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DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Illinois Credit Union Act

2) Code Citation: 38 Ill. Adm. Code 190

3)

| Section Numbers: | Proposed Action: |
|---|---|
| 190.5 | Amendment |
| 190.110 | Amendment |
| 190.165 | Amendment |

4) Statutory Authority: 205 ILCS 305/8

5) A Complete Description of the Subjects and Issues Involved: The amendments to 190.110 and 190.165 provide conformity with the National Credit Union Administration Rules. The amendment to Section 190.5 is a technical amendment due to the change to Section 51(4) of the Act pursuant to Public Act 93-640.

6) Will this proposed rulemaking replace an emergency rule currently in effect? No

7) Does this rule contain an automatic repeal date? No

8) Does the rulemaking contain an incorporation by reference? Yes

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking will not create or expand a State mandate.

11) Time, Place and Manner in which interested parties may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this notice to:

Susan J. Gold
Deputy Counsel
Illinois Department of Financial Institutions
100 W. Randolph
Suite 15-700
Chicago IL 60601
312/814-1524

12) Initial Regulatory Flexibility Analysis:

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENTS

A) Types of small businesses, small municipalities and not for profit corporations affected: Credit Unions

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent regulatory agendas because: it was unclear when or if the amendments would be submitted.

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENTS

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER I: DEPARTMENT OF FINANCIAL INSTITUTIONS

PART 190
ILLINOIS CREDIT UNION ACT

SUBPART A: GENERAL PROVISIONS

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DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENTS

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190.580 Third Party Review

190.APPENDIX A Estimated Monthly Income and Expenses Worksheet
190.APPENDIX B Mortgage Ratio Worksheet

AUTHORITY: Implementing and authorized by the Illinois Credit Union Act [205 ILCS 305].

SOURCE: Adopted at 4 Ill. Reg. 20, p. 17, effective May 7, 1980; amended at 6 Ill. Reg. 11154, effective September 7, 1982; amended and codified at 7 Ill. Reg. 14973, effective October 26, 1983; emergency amendment at 9 Ill. Reg. 14378, effective September 11, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 16231, effective October 10, 1985; amended at 10 Ill. Reg. 14667, effective August 27, 1986; amended at 12 Ill. Reg. 10464, effective June 7, 1988; amended at 12 Ill. Reg. 17383, effective October 24, 1988; amended at 13 Ill. Reg. 3793, effective March 10, 1989; amended at 13 Ill. Reg. 15998, effective October 2, 1989; emergency amendment at 16 Ill. Reg. 12781, effective July 29, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 17073, effective October 26, 1992; amended at 19 Ill. Reg. 2826, effective February 24, 1995; amended at 20 Ill. Reg. 5803, effective April 8, 1996; emergency amendment at 20 Ill. Reg. 13093, effective September 27, 1996, for a maximum of 150 days; emergency expired February 17, 1997; amended at 22 Ill. Reg. 17317, effective September 15, 1998; emergency amendment at 23 Ill. Reg. 3086, effective February 23, 1999, for a maximum of 150 days; emergency expired July 22, 1999; amended at 23 Ill. Reg. 12614, effective October 4, 1999; amended at 23 Ill. Reg. 14031, effective November 12, 1999; amended at 25 Ill. Reg. 6244, effective May 17, 2001; amended at 25 Ill. Reg. 13278, effective October 19, 2001; amended at 26 Ill. Reg. 17999, effective December 9, 2002; amended at 28 Ill. Reg. ______, effective ____________.

SUBPART A: GENERAL PROVISIONS

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENTS

**Section 190.5 Credit Union Service Organizations**

a) The provisions of this Section apply to credit unions investing in or lending to a Credit Union Service Organization (CUSO), which is a credit union organization as defined in Section 1.1 of the Illinois Credit Union Act [205 ILCS 305/1.1].

b) Prior to the initial investment in or loan to a CUSO, the records of the credit union shall contain the following information:

1) The name and location of the CUSO.

2) Services provided by the CUSO.

3) The names of the officers, employees and agents of the CUSO and their relationship to the credit union and the credit union's directors, officers, staff and members.

4) The form of organization under which the CUSO operates, including but not limited to corporation, limited partnership, general partnership, joint venture, limited liability company, or limited partnership.

5) The most recent financial statements of the credit union and the CUSO.

6) The customer base served by the CUSO.

7) The credit union's investments in or loans to other CUSOs.

8) The credit union's indebtedness to any other credit unions, corporations, financial institutions, credit union organizations, or other organizations.

c) A credit union and a CUSO must be operated in a manner that demonstrates to the public the separate corporate existence of the credit union and the CUSO.

1) Good business practices dictate that each must operate so that:

A) Its respective business transactions, accounts, and records are not intermingled;

B) Each observes the formalities of its separate corporate procedures;

C) Each is adequately financed as a separate unit in the light of normal obligations reasonably foreseeable in a business of its size and character;

D) Each is held out to the public as a separate enterprise;

E) The credit union does not dominate the CUSO to the extent that the CUSO is treated as a department of the credit union; and

F) Unless the credit union has guaranteed a loan obtained by the CUSO, all borrowings by the CUSO indicate that the credit union is not liable.

2) Prior to a credit union investing in or making a loan to a CUSO, the credit union must obtain a written legal opinion as to whether the CUSO is established in a manner that will limit potential exposure of the credit union to no more than the loss of funds invested in, or loaned to, the CUSO. In addition, if a CUSO in which a credit union has made an investment or loan plans to change its form of organization under subsection (b)(4) of this Section, the credit union must obtain a prior written legal opinion that the CUSO will remain established in a manner that will limit potential exposure of the credit union to no more than the loss of funds invested in, or loaned to, the CUSO. The legal opinion must address factors that have led courts to "pierce the corporate veil", such as inadequate capitalization, lack of separate corporate identity, common boards of directors and employees, control of one entity over another, and lack of separate books and records. The legal opinion may be provided by independent legal counsel of the credit union.

d) Additional requirements.

1) The CUSO must comply with the definition of a credit union organization as defined by Section 1.1 of the Illinois Credit Union Act [205 ILCS 305/1.1].

2) The amount a credit union may invest in and/or loan to a CUSO is subject to Board of Director approval and the following limitations:

A) Any loan to the CUSO does not cause aggregate loans to credit

union organizations, per Section 51(4) of the Illinois Credit Union Act [205 ILCS 305/51(4)], to exceed the greater of 3%~~1%~~ of the paid-in and unimpaired capital and surplus of the credit union or the amount authorized for federal credit unions.

B) Any investment in the CUSO does not cause the aggregate investment in CUSOs to exceed the greater of 3%~~1%~~ of the paid-in and unimpaired capital and surplus of the credit union in accordance with the statutory limitation on investments in CUSOs or the amount authorized for federal credit unions.

C) The limit on loans to CUSOs is independent and separate from the limit on investments in CUSOs.

D) "Paid-in and unimpaired capital and surplus" means shares, as defined in Section 1.1 of the Illinois Credit Union Act [205 ILCS 305/1.1], and undivided earnings.

E) If the investment limits described in this subsection (d)(2) are reached or exceeded because of the profitability of the CUSO and the related GAAP valuation of the investment under the equity method, without an additional cash outlay by the credit union, divestiture is not required. A credit union may continue to invest up to the authorized amount~~1%~~ without regard to the increase in the GAAP valuation resulting from a CUSO's profitability.

3) All dealings between the credit union's directors, officers, employees, their family members or any corporation, partnership, proprietorship or association in which these individuals hold interest and the CUSO are disclosed. Any agreements between these individuals, businesses or associations and the CUSO must be structured to project economic benefit, increased efficiencies and/or cost effective service to the credit union and must not project a detrimental effect on the earnings or sound operation of the credit union. For purposes of this subsection (d)(3) "family member" means a spouse or a child, parent, grandchild, grandparent, brother or sister, or the spouse of any such individual.

4) All agreements between the credit union and the CUSO must be structured to project economic benefit, increased efficiencies and/or cost effective service to the credit union and must not project a detrimental effect on the

earnings or sound operation of the credit union.

e) Prior to investing in or lending to the CUSO, the credit union must enter into a written agreement with the CUSO.

1) The written agreement must contain clauses that state the CUSO will:

A) Provide the Department with complete access to any books and records of the CUSO, with the costs of examining these records borne by the credit union served in accordance with the per diem rate set out in Section 12 of the Act [205 ILCS 305/12].

B) Follow Generally Accepted Accounting Principles (Wiley GAAP, published by John Wiley & Sons, 605 Third Avenue, New York, NY 10158-0012, 1997 edition, no subsequent dates or editions).

C) Provide the credit union with the financial statements of the CUSO on at least a quarterly basis and Certified Public Accountant (CPA) audited financial statements on an annual basis.

2) The agreement must also contain a clause reciting that the parties agree to terminate their contractual relationship:

A) Upon 90 days written notice to the parties by the Director that the safety and soundness of the credit union is threatened pursuant to the Department's cease and desist and suspension authority as outlined in Section 8(4), 8(5) and 61 of the Act [205 ILCS 305/8(4) and (5) and 61].

B) Immediately upon the parties' receipt of written notice from the Director where the Director reasonably concludes based upon specific facts set forth in the notice to the parties that the credit union will suffer immediate, substantial and irreparable injury or loss if it remains a party to the service contract.

3) The termination of the underlying agreement between the CUSO and the credit union shall in no way operate to relieve the CUSO of repaying any investment, indebtedness or other obligation due and owing the credit union at the time of termination. Any CUSO that was in existence prior to the effective date of this rule and that was legally operating in a manner

that, although inconsistent with this rule, was not in contravention of the Illinois Credit Union Act, may continue its operation until one year from the effective date of this rule.

f) In recording all transactions with the CUSO, Generally Accepted Accounting Principles (see subsection (e)(1)(B)) shall be followed by the credit union.

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

**Section 190.110 Share Drafts**

a) A credit union with total assets of $1 million or less may, upon resolution of the Board of Directors, request Departmental permission to offer share drafts to their members provided that:

1) the total assets of the credit union are ~~greater than $1.0 million or if less, are~~ at a sufficient level to support the additional costs of the program;

2) shares are insured by NCUA or other approved insurance programs;

3) the credit union has full time management or is serviced by a center with full time management;

4) has automated record keeping or is serviced by a center with such equipment; and

5) the financial trends of the credit union, including, but not limited to, the loan delinquency, liquidity, reserves, expense and growth ratios, demonstrate the credit union's ability to manage safely a Share Draft Program.

b) The Department will respond to all applications within 30 days of receipt. If the application is not approved, the disapproval will identify the financial and/or operation characteristics which must be improved before re-application can be made.

c) a credit union with total assets greater than $1 million may, upon resolution of the Board of Directors, offer share drafts to its members without Departmental permission.

d) If dividends on the proposed share draft accounts are to be paid at a different rate or calculated on a basis different from existing common share accountsaccount(s), then in accordance with Section 3738 of the Illinois Credit Union Act [205 ILCS 305/37](Ill. Rev. Stat. 1981, ch. 17, par. 4439), the share drafts must be established as a class of share.

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

**Section 190.165 Business Loans**

a) The following are definitions applicable in this Section.

1) "Associated Member" means any member with a common ownership, investment or other pecuniary interest in a business or commercial endeavor with the borrower.

2) A "Business Loan" is defined as any loan, line of credit, letter of credit (including any unfunded commitments), to a member of the credit union, for which the proceeds will be used to finance a commercial, corporate, other business investment property or venture, or agricultural purpose, including any interest the credit union obtains in a loan made by another lender to a member or nonmember of the credit union if the loan would constitute a business loan if made by the credit union, except that the effect of any interest obtained in nonmember business loans on a credit union's aggregate member business loan limit will be as set forth in subsection (g)(2)(D).

3) "Net Worth" means retained earnings as defined under GAAP. Retained earnings include regularall reserves, undivided earnings and any other appropriations designated by management or regulatory authoritiesand Undivided Earnings or Surplus, excluding the Allowance for Loan Losses Accounts.

4) "Net Member Business Loan Balance" means the outstanding loan balance plus any unfunded commitments, reduced by any portion of the loan that is secured by shares in the credit union, or by shares or deposits in other financial institutions, or by a lien in the member's primary residence, or insured or guaranteed by any agency of the federal government, a state or any political subdivision of such state, or subject to an advance commitment to purchase by any agency of the federal government, a state

or any political subdivision of such state, or sold as a participation interest without recourse and qualifying for true sales accounting under generally accepted accounting principles.

5) "Primary Residence" means the address at which one resides.

6) "Immediate Family Member" means a spouse or other family member living in the same household.

b) Nothing in this Section shall be applicable to:

1) loans fully secured by shares in the credit union or deposits in other financial institutions.

2) net member business loan balances~~loans~~ in an aggregate amount of $50,000 or less to one member or associated member for which the proceeds may be used for a commercial business or agricultural purpose.

3) loans to credit union service organizations (CUSO) as defined under Section 190.5 of this Part.

4) loans for any one to four family owner-occupied parcel of real estate as long as the borrower/owner maintains the subject property as his primary residence.

5) loans fully secured or fully guaranteed by, or subject to an advance commitment to purchase in full by, an agency of the federal government or of a state or any of its political subdivisions.

6) loans granted by a credit union to another credit union.

c) Prohibited Activities

1) A credit union may not grant a member business loan to the following:

A) Chief executive officer;

B) Any assistant chief executive officers;

C) Chief financial officer;

D) Any associated member or immediate family member of anyone listed in subsections (c)(1)(A) through (c)(1)(C).

2) A credit union may not grant a member business loan to a compensated director unless the board of directors approves granting the loan and the compensated director is recused from the decision making process.

3) Equity agreements/joint ventures. A credit union may not a grant a member business loan if any additional income received by the credit union or senior management employees is tied to the profit or sale of the business or commercial endeavor for which the loan is made.

d) Credit unions with assets greater than $30 million may make business loans in accordance with specific lending policies which shall address, but not be limited to:

1) Types of business loans to be made within a designated trade area.

2) A requirement to analyze and document the ability of the borrower to repay the loan consistent with appropriate underwriting and due diligence standards, which also addresses the need for periodic financial statements, credit reports, and other data when necessary to analyze future loans and lines of credit, such as, borrower's history and experience, balance sheet, cash flow analysis, income statements, tax data, environmental impact assessment, and comparison with industry averages, depending upon the loan purpose. ~~Provisions that decisions for business lending be based on prudent lending criteria in assessing the borrower's ability to repay, etc., with appropriate and up-to-date documentation in the file including balance sheets, trend and structure analysis, ratio analysis of cash flow income and expenses, tax data leveraging, updated financial statements, tax returns, etc.~~

3) Expertise Requirement

A) Provisions for ensuring the utilization of services of experienced personnel with at least 2 years of direct experience with the type of business loans the credit union will be making. A credit union may comply with this experience requirement without hiring staff as long as the credit union ensures that the expertise is available.

For example, a credit union may use the services of a CUSO, an employee of another credit union, an independent contractor, or other third parties. However, the actual decision to grant a loan must reside with the credit union.

B) Any third party used by a credit union to meet the requirements of subsection (d)(3)(A) must be independent from the transaction and a credit union is prohibited from using a third party to meet the requirements of this subsection (d) if the credit union is purchasing a business loan, or a participating interest in a business loan, from the third party responsible for reviewing the loan, or if the third party has an interest in the collateral securing a business loan which the third party is responsible for reviewing, with the following exceptions:

i) The third party may provide a service to the credit union related to the transaction, such as loan servicing;

ii) The third party may provide the requisite experience to the credit union and purchase a loan or a participation interest in a loan originated by the credit union that the third party reviewed; or

iii) A credit union may use the services of a CUSO that otherwise meets the requirements of subsection (d)(3)(A) even though the CUSO is not independent from the transaction, provided the credit union has a controlling financial interest in the CUSO as determined under generally accepted accounting principles.

4) The ~~aggregate amount of the credit union assets in relation to net worth that will be invested in business loans, and the~~ maximum amount of secured and unsecured business loans to any one member or group of associated members, provided it does not exceed the limits as set forth in subsections~~subsection~~ (f) and (h)~~(e) below~~.

5) The aggregate amount of the credit union assets in relation to net worth that will be invested in business loans, provided credit unions subject to section 107A of the Federal Credit Union Act (12 USC 1757a) may not exceed the limit set forth in subsection (g).

6) The maximum amount of credit union assets in relation to net worth that will be allotted to given types of business loans.

7)~~6)~~ Collateral requirements, including, but not limited to:

A) Loan-to-value ratios;

B) Determination of value;

C) Determination of ownership;

D) Steps to secure various types of collateral; and

E) How often the credit union will re-evaluate the value and marketability of collateral.

8)~~7)~~ Defined interest rates and defined maturities of business loans.

9)~~8)~~ Loan monitoring, servicing, and follow-up procedures, including collection procedures.

10) Identification of those individuals prohibited from receiving member business loans.

e)~~d)~~ Business loans shall not be granted by credit unions with assets of $30 million or less unless the Department of Financial Institutions has approved a credit union's request for a business loan amendment to its bylaws. The request must be accompanied with specific lending policies including but not limited to the criteria listed in subsection (d~~e~~). All approval of requests shall be based upon the history of the credit union, current financial condition and the adequacy of applicable operating policies as documented in the Department's statutory~~annual~~ or special examination. Evaluation of the history, current financial condition, and operating policies of the credit union will include, but not be limited to, the credit union's capital adequacy, asset quality, management policies, earnings, and liquidity. These factors must be reflective of a safe and sound financial operation (in accordance with 205 ILCS 305/8, 9, 36 and 61).

f)~~e)~~ The net member business loan balances of~~Business loans to~~ any one member or group of associated members shall not exceed 15% of the credit union's net worth.

~~The amount of business loans is determined by adding the total outstanding balance of business loans to one member or group of associated members and subtracting any portion: 1) Secured by shares in the credit union or by deposits in another financial institution; 2) Fully or partially insured or guaranteed by any agency of the federal government, a state or its political subdivisions; and 3) Subject to an advance commitment to purchase by any agency of the federal government, a state or its political subdivisions.~~ Credit unions seeking an exception to this limit must request a waiver in writing. The maximum limit on a member business loan is in addition to the secured and unsecured limits established in Sections 190.160 and 190.140, provided however, in no event shall all loans to any member exceed in the aggregate 10% of the credit union's unimpaired capital and surplus.

g) Aggregate Member Business Loan Limit

1) The aggregate limit on the net member business loan balances of a credit union subject to section 107A of the Federal Credit Union Act (12 USC 1757a), excluding any business loans exempted from the aggregate member business loan limit by section 107A of the Federal Credit Union Act or Part 723 of the National Credit Union Administration Regulations (12 CFR 723), is the greater of:

A) 1.75 times the credit union's net worth or 12.25% of the credit union's assets, whichever is less; or

B) the aggregate member business loan limit authorized by section 107A of the Federal Credit Union Act.

2) Exceptions to the aggregate loan limit for a credit union include:

A) Credit unions that have a low-income designation or participate in the Community Development Financial Institutions program;

B) Credit unions that were chartered for the purpose of making member business loans and can provide documentary evidence (such evidence includes but is not limited to the original charter, original bylaws, original business plan, original field of membership, board minutes and loan portfolio).

C) Credit unions that have a history of primarily making member business loans, meaning that either member business loans comprise at least 25% of the credit union's outstanding loans (as evidenced in any call report or any equivalent documentation including financial statements) or member business loans comprise the largest portion of the credit union's loan portfolio (as evidenced in any call report or any equivalent documentation including financial statements). For example, if a credit union makes 23% member business loans, 22% first mortgage loans, 22% new automobile loans, 20% credit cards loans, and 13% total other real estate loans, then the credit union meets this exception.

D) If the interest held by a credit union in any loans made by another lender to a nonmember of the credit union would constitute a business loan if made to a member of the credit union, the total of the interest held in such nonmember business loans plus the credit union's net member business loan balances must not exceed the aggregate limit set forth in subsection (g)(1), unless the credit union has requested approval from the Department, by submitting an application that:

i) Includes a current copy of the credit union's member business loan policies;

ii) Confirms that the credit union is in compliance with all other aspects of this Section;

iii) States the credit union's proposed limit on the total amount of nonmember business loan interests that the credit union may acquire if the application is granted; and

iv) Attests that the acquisition of an interest in nonmember business loans is not being used, in conjunction with one or more other credit unions, to have the effect of trading member business loans that would otherwise exceed the aggregate limit.

3) Request for Exception

A) An exception under subsection (g)(2)(A) is effective upon written notice to the Department of such designation or participation.

B) An exception under subsection (g)(2)(B) or (g)(2)(C) must be submitted in writing to the Department, including documentation demonstrating that the credit union meets the criteria for the exception.

i) Approval of an exception shall be given in writing to the credit union.

ii) The exception does not expire until revoked for safety and soundness reasons by the Department.

iii) The Department shall notify the respective Region of the NCUA of the decision on the request.

h)~~f)~~ Collateral

1) Unless the Department grants a waiver, all member business loans, except those made under subsections (h)(2), (3) and (4), must be secured by collateral. The maximum loan to value (LTV) ratios for all liens shall not exceed 80%, unless the loan amount in excess of 80% is covered through private mortgage or equivalent insurance, or is insured or guaranteed by or subject to an advance commitment to purchase by any agency of the federal government or a state or its political subdivisions, but in no case shall the LTV exceed 95%. ~~as follows~~:

~~A) Loan to value (LTV) ratios shall not exceed 80%, unless the loan amount in excess of 80% is covered through private mortgage or equivalent insurance but in no case shall the LTV exceed 95%.~~

~~B) With respect to first mortgages, business loans with LTV ratios greater than 80% may be granted if the loan amount in excess of 80% is covered through private mortgage or equivalent insurance, or is insured or guaranteed by or subject to an advance commitment to purchase by any agency of the federal government, a state or its political subdivisions.~~

2) Unsecured member business loans may be made if:

A) The credit union has a current net worth of 7% or, if applicable, meets its risk based net worth ratio, whichever is higher;

B) The aggregate of the unsecured outstanding member business loans to any one member or group of associated members does not exceed the lesser of $100,000 or 2.5% of the credit union's net worth; and

C) The aggregate of all unsecured outstanding member business loans does not exceed 10% of the credit union's net worth.

3)2) Credit card line of credit programs offered to nonnatural person members, or guaranteed by nonnatural persons, that are limited to routine purposes normally made available under those programs are exempt from the collateral requirement of subsections (h)(1) and (2)of this subsection (f).

4) Credit unions may make vehicle loans under this Section without complying with the loan-to-value ratios in this Section, provided that the vehicle is a car, van, pick-up truck, or sports utility vehicle and not part of a fleet of vehicles.

i)g) Construction Loans
Unless the Department grants a waiver, loans granted for the construction or development of commercial or residential property are subject to the following additional requirements:

1) The aggregate of all construction and development net member business loan balancesloans must not exceed 15% of the credit union's net worth. The following loans or portions thereof may be excluded from the calculation of the aggregate:

A) loans made to finance the construction of a single-family residence if a prospective homeowner has contracted to purchase the propertyloans secured by shares in the credit union or by deposits in another financial institution; and

B) a loan to finance the construction of one single-family residence per member-borrower or group of associated member-borrowers, irrespective of the existence of a contractual commitment from a

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prospective homeowner to purchase the property;loans fully or partially insured or guaranteed by any agency of the federal government, a state or its political subdivisions; or

C) loans subject to an advance commitment to purchase by any agency of the federal government, a state or its political subdivisions;

2) The borrower must have a minimum of 25%35% equity interest in the project being financed, the value of which is determined by the market value of the project at the time the loan is made, except that the loan to value requirements of subsection (h) shall apply in lieu of this equity interest requirement in the case of loans made to finance the construction of a single-family residence if a prospective homeowner has contracted to purchase the property and in the case of one loan to a member-borrower or group of associated member-borrowers to finance the construction of a single-family residence, irrespective of the existence of a contractual commitment from a prospective homeowner to purchase the property; and

3) The funds may be released only after on-site, written inspections by qualified personnel and according to a preapproved draw schedule and any other conditions as set forth in the loan documentation.

j)h) Request for Waiver

1) Credit unions may request a waiver for a category of business loans in the following areas:

A) Maximum secured and unsecured loan amounts to one borrower or associated group of borrowers under subsectionssubsection (f) and (h)(e);

B) Maximum aggregate unsecured member business loan limit under subsection (h)(2);

C) Collateral requirements under subsection (h)(f);

D)C) The aggregate amount of construction loans and the minimum equity interest in construction loans under subsection (i)(g); and

E)D) Any appraisal requirements imposed by Part 190 with respect to loans secured by real estate.

2) A request for a waiver must be submitted in writing to the Department. The waiver request must contain the following:

A) A copy of the credit union's business lending policy;

B) The waiver sought;

C) An explanation of the higher limits sought (if applicable);

D) Documentation supporting the credit union's ability to manage this activity; and

E) An analysis of the credit union's prior experience in making member business loans, including the credit union's history of loan losses and delinquency, volume and cyclical or seasonal patterns, diversification, concentrations of credit to one borrower or group of borrowers in excess of 15% of net worth, underwriting standards and practices, types of loans grouped by purpose and collateral, and the qualifications of personnel responsible for underwriting and administering member business loans.

3) The Department shall consider standard criteria when determining whether to grant a waiver requested by a credit union as provided in subsection (j)(h)(1) of this Section. The criteria include but are not limited to:

A) The two most recent Departmental examinations;

B) The credit union's reserve/equity position;

C) The credit union's current delinquency and loan loss trends; and

D) The credit union's Business Lending Policy and Procedures.

4) The Department shall respond to requests for waivers as follows:

A) The Department shall inform the credit union in writing of the date the written request for waiver was received.

B) Approval of waivers shall be given in writing within 45 calendar days from receipt of the waiver request and supporting documents listed in subsection (j)~~(h)~~(2)~~of this Section~~, if it is determined by the Department that the waiver will not adversely affect the credit union's financial position.

C) If a waiver approved by the Department must also be approved by the National Credit Union Administration (NCUA), the Department shall forward the waiver request and supporting documents to the NCUA Regional Director and provide the credit union with written notice of the date the request was forwarded.

D) If a waiver request does not require NCUA approval, the credit union may assume approval of the waiver request if it does not receive notification within 45 days after the date the request was received by the Department.

k) Recordkeeping Requirements
Business loans must be separately identified in a credit union's records and separately identified in the aggregate on a credit union's financial reports.

l)~~i)~~ Allowance for Loan Losses for Business Loans

1) Allowance for Loan Losses for Business Loans will be determined and accounted for by the credit union ~~according to Section 190.70~~ as follows:

A) Substandard Loans – A substandard loan is one that is inadequately protected by the current sound worth and paying capacity of the obligor or of the collateral pledged. Loans classified substandard have a well-defined weakness or weaknesses that jeopardize the liquidation of the debt. They are characterized by the distinct possibility that the credit union will sustain some loss if the deficiencies are not corrected. Loans listed in this category shall generally be listed in a range from zero to under 50% potential loss.

B) Doubtful Loans – A loan classified doubtful has all the weaknesses inherent in a loan classified substandard, with the added characteristic that the weaknesses make collection or liquidation in

full, on the basis of currently existing facts, conditions, and values, highly questionable and improbable. The possibility of loss is extremely high, but because of certain important and reasonable specific pending factors that may work to the advantage and strengthening of the loan, its classification as an estimated loss is deferred until a more exact status may be determined. Pending factors include: proposed merger, acquisition, or liquidation actions; capital injection; perfecting liens on collateral; and refinancing plans. Loans in this category shall be listed at a minimum 50% potential loss.

C) Loss Loans – Loans classified loss are considered uncollectible and of such little value that their continuance as loans on the credit union balance sheet is not warranted. This classification does not necessarily mean that the loan has absolutely no recovery or salvage value, but rather, it is not practical or desirable to defer writing off the asset even though partial recovery may occur in the future. Loans in this category shall be listed at 100% potential loss.

D) Loans may be excluded from the "loss loans" category and classified as either substandard or doubtful if there is evidence of collectibility. Evidence of collectibility shall include without limitation the following collection activities and remedies:

i) Execution and filing of an enforceable reaffirmation agreement on the loan in a Chapter 7 bankruptcy (11 USC 701 et seq.) proceeding prior to completion of the Department's loan analysis in any statutory examination of the credit union.

ii) Receipt of payments on the loan in a Chapter 13 bankruptcy (11 USC 1301 et seq.) within 180 days after the confirmation of the plan; or, if the plan stipulates repayment of the loan in full but payments have not yet been disbursed to the credit union, the credit union has determined from the Trustee that plan payments are being made on a timely basis to the Trustee.

iii) Receipt of payments on the loan in a Chapter 11 bankruptcy reorganization (11 USC 1101 et seq.) or Chapter 12 bankruptcy family farm reorganization (11 USC 1201 et seq.) within 180 days after the confirmation of the plan.

iv) Voluntary repayment of the loan pursuant to Section 524(f) of the federal Bankruptcy Code (11 USC 524(f)).

v) Collection of the loan pursuant to repossession of collateral without judicial process, or by replevin, detinue, forcible entry and detainer or mortgage foreclosure proceedings.

vi) Collection of the loan pursuant to post-judgment enforcement remedies, including wage deduction, garnishment and turnover orders entered in citation to discover assets supplementary proceedings.

vii) The entry of a judgment pay plan order providing for repayment of the loan in a judicial proceeding.

viii) Documented evidence of repayment of that portion of the loan covered by collateral protection or other insurance policies.

ix) Documentation evidence of periodic payments on a consistent basis in an amount sufficient to retire the loan balance in a reasonable time.

2) Non-delinquent loans may be classified in the above categories by the Department, dependent upon an evaluation of factors, including, but not necessarily limited to, the adequacy of the credit union's analysis and documentation of the loan application, and the credit union's collateral requirements. Subsection (d)~~(e)~~(2) ~~above~~ contains analysis and documentation requirements.

~~j) Credit unions authorized to make business loans may make member business loans to its directors, officers, credit committee members and supervisory committee members provided that the loan complies with all lawful requirements~~

~~as set forth in this Section and in Section 52 of the Illinois Credit Union Act and is not on terms more favorable than those extended to other borrowers.~~

~~k) Credit unions authorized to make business loans shall not grant member business loans if the amount of income desired/received by the credit union is tied to the profit of the business in the form of an equity participation.~~

~~l) Credit unions are prohibited from making business loans where the payment amount fluctuates with the earnings of the business/borrower.~~

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

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1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3)

| Section Numbers: | Proposed Action: |
|---|---|
| 140.80 | Amendment |
| 140.82 | Amendment |
| 140.84 | Amendment |

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-0659

5) Complete Description of the Subjects and Issues Involved: These proposed amendments pertain to the Department's provider fund rules.

Section 140.80, Hospital Provider Fund, is being revised pursuant to Public Act 93-0659, to establish a new annual assessment on hospital inpatient services. These changes are expected to increase the Hospital Provider Fund by approximately $558 million.

Section 140.82, Developmentally Disabled Care Provider Fund, and Section140.84, Long Term Care Provider Fund, are being revised to provide clarifications on granting penalty waivers by the Assessment Unit staff, and to more closely align the rules with related procedures.

6) Will these proposed amendments replace any emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

| Sections | Proposed Action | Illinois Register Citation |
|---|---|---|
| 140.19 | Amendment | January 23, 2004 (28 Ill. Reg. 1330) |
| 140.491 | Amendment | March 26, 2004 (28 Ill. Reg. 5167) |
| 140.645 | Amendment | February 27, 2003 (27 Ill. Reg. 3700) |

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

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11) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Public Aid
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002
(217)524-0081

The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded hospitals and long term care facilities will be affected by this rulemaking. The Department is unsure whether any of the affected entities may qualify as small businesses.

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: These proposed amendments were not included on either of the two most recent agendas because: This rulemaking was inadvertently omitted when the most recent regulatory agenda was published.

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The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under Medical Assistance Programs
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under General Assistance
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

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140.12 Participation Requirements for Medical Providers
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140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
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140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination on Individuals Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
140.20 Submittal of Claims

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140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
140.22 Magnetic Tape Billings (Repealed)
140.23 Payment of Claims
140.24 Payment Procedures
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140.73 Drug Manual Updates (Recodified)

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140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
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140.97 Special Requirements (Recodified)
140.98 Covered Hospital Services (Recodified)
140.99 Hospital Services Not Covered (Recodified)
140.100 Limitation On Hospital Services (Recodified)
140.101 Transplants (Recodified)
140.102 Heart Transplants (Recodified)

140.103 Liver Transplants (Recodified)
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140.110 Disproportionate Share Hospital Adjustments (Recodified)
140.116 Payment for Inpatient Services for GA (Recodified)
140.117 Hospital Outpatient and Clinic Services (Recodified)
140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
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140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
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SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

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140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].
SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, l983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill.

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Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302;

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amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14,

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1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30,

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1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days;

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emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective

February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; amended at 28 Ill. Reg. ______, effective ____________.

SUBPART C: PROVIDER ASSESSMENTS

**Section 140.80 Hospital Provider Fund**

a) Purpose and Contents

1) The Hospital Provider Fund ("Fund") was created in the State Treasury upon enactment of Public Act 93-065987-861, Public Act 88-88, Public Act 89-21 and Public Act 89-499. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 93-065987-861, as amended by Public Act 88-88, Public Act 89-21 and Public Act 89-499.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Sectionbelow;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) Monies transferred from another fund in the State treasury;

ED) All other monies received for the Fund from any other source,

including interest earned on those monies.thereon;

E) All monies transferred from the Hospital Services Trust Fund; and

F) All monies transferred from the Tobacco Products Tax Act.

b) Provider Assessments
An annual assessment on hospital inpatient services is imposed on each hospital provider for State fiscal years 2004 and 2005 in an amount equal to the hospital's occupied bed days multiplied by $84.19. The Department shall use the number of occupied bed days as reported, by February 3, 2004 (the date of enactment of Public Act 93-0659), by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.Effective July 1, 1994, through June 30, 1996, an annual assessment is imposed upon each hospital provider in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (l)(1) of this Section, for the most recent calendar year ending before the beginning of that fiscal year, multiplied by a Provider's Savings Rate. Effective July 1, 1996, through March 31, 1997, an assessment is imposed in an amount equal to three-fourths of the Provider's adjusted gross hospital revenue for calendar year 1995 multiplied by the Provider's Savings Rate.

1) Effective July 1, 1994, through June 30, 1995, the Provider's Savings Rate is obtained by multiplying 1.88 percent by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which equals the Maximum Section 5-2 Contribution (see subsections (l)(2), (8) and (10) of this Section).

2) Effective July 1, 1995, through March 31, 1997, the Provider's Savings Rate is obtained by multiplying 1.25 percent by the fraction described in subsection (b)(1) above.

3) The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by

~~the records of the Department.~~

c) Payment of Assessment Due

1) The annual assessments imposed for State fiscal year 2004 shall be due and payable on June 18, 2004. The assessment imposed for State fiscal year 2005~~in subsection (b) above~~ shall be due and payable in quarterly installments, each equaling~~equalling~~ one-fourth of the assessment for the year, on July 19~~September 30~~, October 19~~December 31~~, January 18~~March 31~~, and April 19~~May 31~~ of the year~~, modified to accommodate weekends and holidays, except that for fiscal year 1997 (July 1, 1996 through June 30, 1997), the assessment imposed shall be due and payable in three equal installments on September 30, December 31 and March 31. Providers will be notified, in writing, of the due dates~~. ~~Assessment payments postmarked on the due date will be considered as paid on time.~~ No installment payments of an assessment shall be due and payable, however, until after:

A) the hospital provider receives written notice from the Department that the payment methodologies to hospitals required under Public Act 93-0659 have been approved by the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services and the waiver under 42 CFR 433.68 for the assessment has been granted by the Centers for Medicare and Medicaid Services; and

B) the hospital has received payments required under Public Act 93-0659. Assessment payments postmarked on the due date will be considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Notice~~Reporting~~ Requirements, Penalty, and Maintenance of Records

1) After December 31 of each year, and on or before March 31 of the succeeding year, the Department shall send a notice of assessment to every hospital provider subject to an assessment under subsection (b) of this Section~~above~~, except that the notice for the State fiscal year commencing July 1, 2003, shall be sent on or before June 1, 2004, and no notice shall be sent until the Department receives written notice that the payment

methodologies to hospitals required under Public Act 93-0659 have been approved by the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services and the waiver under 42 CFR 433.68 for the assessment has been granted by the Centers for Medicare and Medicaid Services. ~~shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross hospital revenue from the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1.~~

2) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate notice shall be sent~~report shall be filed~~ for each hospital.~~ In the case of a hospital provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.~~

~~2) If the hospital provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25 percent of the assessment imposed for the year.~~

~~3) Every hospital provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross hospital revenue on a calendar year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.~~

~~4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.~~

~~5) Submission of Financial Audit Statements. All hospital providers are~~

~~required to submit a copy of all financial statements audited by an external, independent auditor, to the Department within 30 days after the close of such externally performed financial audits. If the hospital's year end does not coincide with the December 31 ending date for the assessment report, the hospital must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.~~

~~6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a hospital provider, the hospital provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.~~

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) of this Section~~above~~, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Section by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate or maintain a hospital, the person~~The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and~~ shall pay the assessment for the year as adjusted (to the extent not previously paid)~~with the final return the assessment for the year as so adjusted, to the extent not previously paid~~.

2) Commencing of business during the fiscal year in which the assessment is

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being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) of this Section~~above~~, upon notice by the Department,~~shall file an initial report for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and~~ shall pay the assessment under subsection (d) of this Section~~above~~ as computed by the Department in ~~equal~~ installments on the due dates stated on the notices ~~date of the initial assessment determination~~ and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment notice~~determination~~. In determining the annual assessment amount for the provider, the Department shall develop hypothetical annualized occupied bed~~revenue~~ projections based upon geographic location, facility size and patient case mix or, if there is not enough information to develop a methodology, may base the projection on the average occupied bed percentage of all hospitals in the State. The assessment determination made by the Department is final.

3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the ~~following~~ State fiscal year shall be annualized based on the provider's actual occupied bed information~~revenues~~ for the portion of the reporting period the hospital was operational (dividing occupied beds~~adjusted gross hospital revenue~~ by the number of days the hospital was in operation and then multiplying the amount by 365). Occupied bed information reported~~Revenues realized~~ by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period~~month~~ thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Waiver due to reasonable cause may include but is not limited to:

A) A provider can demonstrate to the Department's satisfaction that a payment was made prior to the due date.

B) A provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30~~45~~ days after~~from~~ the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's~~Department~~ rules at ~~contained in~~ 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section~~above~~ will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30~~45~~ days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within

three months after~~of~~ the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Hospitals
The Department~~Director~~ may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to State~~state~~ cash flow; or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Hospitals
In addition to the provisions of subsection (g) of this Section~~above~~, the Department~~Director~~ may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section~~above~~.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) of this Section~~above~~ would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have

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caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) a hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital (DSH) under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section~~above~~.

iii) a hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criteria under subsection (h)(1)(A)(ii) of this Section~~above~~.

C) the provider must file a delay of payment request as defined under subsection (h)(3)(A) of this Section~~below~~, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are

unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Sectionbelow that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The

DepartmentDirector may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process.

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section~~above~~, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~. The interest may be waived by the Department~~Director~~ if the facility's current ratio, as described in subsection (h)(1)(C) of this Section~~above~~, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) of this Section~~above~~. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) of this Section ~~above~~ shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions
Pursuant to Section 5A-7 of Public Act~~P.A.~~ 86-861, to the extent practicable, the Department shall administer and enforce Public Act~~P.A.~~ 86-861, Public Act ~~P.A.~~ 88-88, Public Act~~P.A.~~ 89-21 and Public Act~~P.A.~~ 89-499, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers'

Occupation Tax Act ("ROTA").

j) Exemptions
The following classes of providers are exempt from the assessment imposed under Public Act 93-0659 unless the exemption is adjudged to be unconstitutional or otherwise invalid:

1) A hospital provider that is a State agency, a State university, or a county with a population of 3,000,000 or more.

2) A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit.

3) A hospital provider whose hospital does not charge for its services.

4) A hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital.

5) A hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital.

6) A hospital provider whose hospital is not a psychiatric hospital, rehabilitation hospital, or children's hospital and has an average length of inpatient stay greater than 25 days.

~~1) A rural hospital, as defined in subsection (l)(11) below, shall be exempt from the assessment imposed under subsection (b), unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessment imposed under subsection (b) above.~~

~~2) A hospital provider which is a county with a population of more than 3,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861, P.A. 88-85, P.A. 88-88 and P.A. 89-21, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.~~

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~~3) The Department is authorized to enter into an interagency agreement with a hospital organized under the University of Illinois Hospital Act and exempt from the assessment imposed under subsection (b) of this Section, to make intergovernmental transfer payments to the Department. Effective July 1, 1994, these payments shall be deposited into the University of Illinois Fund, as mandated under P.A. 88-554.~~

~~4) The Department is also authorized to enter into agreements with publicly owned or operated hospitals not described in subsections (j)(1) through (j)(3) above to make intergovernmental transfer payments to the Department. These payments shall be deposited into the Hospital Provider Fund.~~

~~5) Facilities operated by the Department of Mental Health and Developmental Disabilities shall be exempt from the assessment imposed by subsection (b) above.~~

k) Nothing in Public Act 93-0659~~89-499~~ shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before February 3, 2004 (the effective date of Public Act 93-0659)~~P.A. 89-499~~.

l) Definitions.
As used in this Section, unless the context requires otherwise:

~~1) "Adjusted gross hospital revenue" means the hospital provider's total gross patient charges less Medicare contractual allowances, but does not include gross patient revenue from skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act, or home health and hospice services (and the portion of any Medicare contractual allowance related thereto). Revenue generated from swing beds, as described in subsection (l)(12) below, is considered to be part of the provider's gross hospital revenue. Revenue not related to patient care, such as, investment income, gift shop, cafeteria, or parking lot revenue is not considered as patient revenue. Adjusted gross hospital revenue must be reported on an accrual basis for the assessment reporting period. All patient revenue accrued during the assessment reporting period must be included even though reimbursement may occur after the assessment reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the hospital's last two cost reports.~~

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~~2) "Cigarette Tax Contribution" is the sum of the total amount deposited in the Hospital Provider Fund in the previous State fiscal year pursuant to Section 2(a) of the Cigarette Tax Act, plus the total amount deposited in the Hospital Provider Fund in the previous State fiscal year pursuant to Section 5A-3(c) of Public Act 88-88, as amended by Public Act 89-21.~~

1~~3~~) "Department" means the Illinois Department of Public Aid.

2~~4~~) "Fund" means the Hospital Provider Fund.

3~~5~~) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

4~~6~~) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

5) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding beds classified as long term care beds and assessed a licensed bed fee during calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

~~7) "Intergovernmental transfer payment/Interagency Agreement" means the payments established under Section 15-3 of P.A. 87-861, P.A. 88-85, P.A. 88-88 and P.A. 88-554, and includes without limitation payments payable under that Section for July, August and September of 1992.~~

~~8) "Maximum Section 5A-2 Contribution" is the total amount of tax imposed by Section 5A-2 of Public Act 88-88, as amended by Public Act 89-21, in the previous State fiscal year on providers subject to the assessment imposed by subsection (b) above; multiplied by a fraction the numerator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for the~~

~~previous State fiscal year and the denominator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for the State fiscal year immediately preceding the previous State fiscal year.~~

~~9) "Medicare Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by Medicare, as appropriate, pursuant to agreements between the hospital and the Health Care Financing Administration.~~

~~10) "Provider's Savings Rate" effective July 1, 1994, is 1.88 percent multiplied by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which is the Maximum Section 5A-2 Contribution. Effective July 1, 1995, through March 31, 1997, the Provider's Savings Rate is 1.25 percent multiplied by the same fraction as described above.~~

~~11) "Rural hospital" means a hospital that is:~~

~~A) located outside a metropolitan statistical area;~~

~~B) located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and had a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health; or~~

~~C) qualified as a rural hospital by meeting subsection (1)(11)(A) or (B) above as of July 14, 1993.~~

~~12) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993). Appeals of the geographic designation of a hospital provider shall be in accordance with 89 Ill. Adm. Code 148.310(m).~~

~~13) "Swing beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR~~

~~409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).~~

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

**Section 140.82 Developmentally Disabled Care Provider Fund**

a) Purpose and Contents

1) The Developmentally Disabled Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861, Public Act 88-88 and Public Act 89-21. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section, Public Act 87-861, Public Act 88-88 and Public Act 89-21.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Section~~below~~;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon; and

E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments
Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider in an amount equal to six percent of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. The

revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data.

c) Payment of Assessment Due

1) The assessment described in subsection (b) of this Sectionabove shall be due and payable in quarterly installments, each equalingequalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) of this Sectionabove shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) of this Sectionabove a penalty assessment equal to 25 percent of the assessment imposed for the year.

3) Every developmentally disabled care provider subject to an assessment under subsection (b) of this Sectionabove shall keep records and books that will permit the determinationdeterminiation of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsectionsubsections (d)(5) or (6) of this Sectionbelow, an amended assessment report must be filed within 30 calendar days afterof the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days afterof the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30 ending date for the assessment report, the provider must submit all financial audits covering the tax report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial tax report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days afterof the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility for which the person is subject to assessment under subsection (b) of this Sectionabove, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Sectionabove by a fraction, the numerator of which is the number of monthsdays in the year during which the provider conducts, operates, or maintains the facility and the denominator of which is 12365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility for which the person is subject to assessment under subsection (b) of this Sectionabove, shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) of this Sectionabove as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of monthsdays the facility was in operation and then multiplying that amount by 12365). Developmentally disabled care revenue realized by a prior provider from

the same facility during the fiscal year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period ~~month~~ thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Reasonable cause may include but is not limited to:

A) a provider who has not been delinquent on payment of an assessment due within the last three calendar years from the time the delinquency occurs;

B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or

C) that the provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30~~45~~ days after~~from~~ the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire

provider assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's~~Department~~ rules at~~contained in~~ 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section~~above~~ will continue to accrue during the recoupment process. Recoupment proceedings against the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30~~45~~ days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Facilities~~.~~
The Department~~Director~~ may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State~~state~~ cash flow; or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Facilities
In addition to the provisions of subsection (g) of this Section~~above~~, the Department~~Director~~ may delay assessments for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of

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the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section~~above~~.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

   A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) of this Section~~above~~ would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

      i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

      ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

   B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

      i) 85 percent or more of their residents must be eligible for public assistance;

      ii) a government-owned facility, which meets the cash flow criteria under subsection (h)(1)(A)(ii) of this Section~~above~~.

      iii) a provider who has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section~~above~~.

   C) the facility must file a delay of payment request as defined in

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subsection (h)(3)(A) of this Section~~below~~, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets have~~has~~ been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow the assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Section~~below~~ that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility that~~which~~ does not meet the ~~above~~ criteria listed in subsection (h)(1) may request a delayed payment schedule ~~and/or the waiver of interest and penalties~~. The Department~~Director~~ may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule ~~and/or waiver of interest and penalties~~ is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the

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telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section~~above~~, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties~~penalities~~ shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~. The interest may be waived by the Department~~Director~~ if the facility's current ratio, as described in subsection (h)(1)(C) of this Section,~~above~~ is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B) of this Section~~above~~. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) of this Section~~above~~ shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions~~; enforcement provisions~~
Pursuant to Section 5C-6 of Public Act~~P.A.~~ 86-861, to the extent practicable, the Department shall administer and enforce Public Act~~P.A.~~ 86-861, Public Act~~P.A.~~ 88-88 and Public Act~~P.A.~~ 89-21, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in Public Act~~P.A.~~ 89-21 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of Public Act~~P.A.~~ 89-21.

k) Definitions

1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.

2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors

or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the ~~Illinois~~ Department ~~of Public Aid~~.

3) "Department" means the Illinois Department of Public Aid.

4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" (subsection (k)(4))~~above~~.

7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

**Section 140.84 Long Term Care Provider Fund**

a) Purpose and Contents

1) The Long Term Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861, Public Act 88-88 and Public Act 89-21. Interest earned by the Fund shall be credited to the Fund. The Fund~~fund~~ shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, Public Act 88-88 and

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Public Act 89-21.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) of this Sectionbelow;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon;

E) All monies transferred from the Medicaid Long Term Care Provider Participation Fee Trust Fund; and

F) All monies transferred from the Tobacco Products Tax Act.

b) License Fee
Beginning on July 1, 1993, a nursing home license fee is imposed upon each nursing home provider in an amount equal to $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. All nursing beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(8) of this Section will be used to calculate the licensed nursing bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Changes in the number of licensed nursing beds will be reported to the Department quarterly, as described in subsection (d)(1) of this Sectionbelow. The Department reserves the right to audit the reported data.

c) Payment of License Fee Due

1) The license fee described in subsection (b) of this Sectionabove shall be due and payable in quarterly installments, on September 10, December 10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be

considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

3) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their license fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 USC~~U.S.C.~~ 1396~~ et seq.~~), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after~~of~~ the final approval of the county budget;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) On or before the due dates described in subsection (c)(1) of this Section, each nursing home provider subject to a license fee under subsection (b) of this Section shall file a report with the Department reflecting any changes

in the number of licensed nursing beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) of this Sectionabove, all changes in licensed nursing beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed nursing beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Public Aid with the licensed nursing bed change form. If a nursing home provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a nursing home provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee imposed in subsection (b) of this Sectionabove a penalty fee equal to 25 percent of the license fee imposed for the year.

3) Every nursing home provider subject to a license fee under subsection (b) of this Sectionabove shall keep records and books that will permit the determination of licensed nursing bed days on a quarterly basis. All such books and records shall be maintained for a minimum of three years following the filing date of the license fee report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended License Fee Reports. With the exception of amended license fee reports filed in accordance with subsectionsubsections (d)(5) of this Sectionbelow, an amended license fee report must be filed within 30 calendar days of after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual license fee amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Reconsideration of Adjusted License Fee. If the Department, through an

audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment license fee was due, changes the license fee liability of a nursing home provider, the nursing home provider may request a review or reconsideration of the adjusted license fee within 30 days after~~of~~ the Department's notification of the change in license fee liability. Requests for reconsideration of the license fee adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the quarter in which the license fee is being paid and the closure date has been set. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section~~above~~, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the quarter in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting quarter and shall be submitted with the final quarterly payment. Example: A facility is set to close on September 24. On or before the due date for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of operation (July 1 through September 24) and the corresponding quarterly license fee payment.

2) Cessation of business after the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section~~above~~, and for which closure occurs after the due date for the reporting quarter, but prior to the last day of the reporting quarter, shall file an amended final report with the Department within 30 days after~~of~~ the closure date. The amended report will reflect the number of days the facility was operational during the reporting quarter and the revised license fee amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes on December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27) must be filed with the Department.

3) Cessation of business prior to the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) of this Section~~above~~, and for which closure occurs prior to the due date for the reporting quarter, shall file a final report with the Department within 30 days after~~of~~ the closure date. The final report will reflect the number of days the facility was operational during the reporting quarter and the corresponding final license fee amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

4) Commencing of business during the fiscal year in which the license fee is being paid. A nursing home provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee imposed under subsection (b) of this Section~~above,~~ shall file an initial report for the reporting quarter in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee under subsection (d) of this Section~~above~~.

5) Change in Ownership and/or Operators. The full quarterly assessment/license fee must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the nursing home provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any nursing home provider that fails to pay the full amount of an

installment when due, or fails to report a change in licensed nursing beds approved by the Department of Public Health prior to the due date of the installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period~~month~~ thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Reasonable cause may include but is not limited to:

A) a provider who has not been delinquent on payment of an assessment due, within the last three calendar years from the time the delinquency occurs;

B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or

C) that the provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30~~45~~ days after~~from~~ the due date, the Department may begin recovery actions against delinquent nursing home providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if a provider fails to comply with an agreement, the Department reserves the right to recover any outstanding license fee, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's~~Department~~ rules at~~contained in~~ 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section~~above~~ will continue to accrue during the recoupment process. Recoupment proceedings against the same nursing home provider two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30~~45~~ days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the nursing home provider does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after~~of~~ the license fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Facilities
The Department~~Director~~ may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State~~state~~ cash flow; or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment – Individual Facilities
In addition to the provisions of subsection (g) of this Section~~above~~, the Department~~Director~~ may delay license fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the license fee was to have been received by the Department as described in subsection (c) of this Section~~above~~.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) of this Section~~above~~ would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or

clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance;

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section~~above~~.

iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion~~criteria~~ under subsection (h)(1)(A)(ii) of this Section~~above~~.

C) the facility must file a delay of payment request as defined under subsection (h)(3)(A) of this Section~~below~~ and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of license fee payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the license fee payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Section~~below~~ that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility that~~which~~ does not meet the above criteria may request a delayed payment schedule~~ and/or the waiver of interest and penalties~~. The Department~~Director~~ may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule ~~and/or waiver of interest and penalties ~~is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section~~above~~; a denial of application to borrow the license fee as defined in subsection (h)(1)(D) of this Section~~above~~ and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the license fee due date, of the Department's decision with regard

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to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section~~above~~ may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section~~above~~, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~. The interest may be waived by the Department~~Director~~ if the facility's current ratio, as described in subsection (h)(1)(C) of this Section~~above~~, is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section~~above~~.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) of this Section~~above~~ shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions ~~ enforcement provisions~~
Pursuant to Section 5B-7 of Public Act ~~P.A.~~ 87-861, to the extent practicable, the Department shall administer and enforce Public Act~~P.A.~~ 86-861, Public Act ~~P.A.~~ 88-88 and Public Act~~P.A.~~ 89-21, and collect the license fees, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in Public Act~~P.A.~~ 89-21 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of Public Act~~P.A.~~ 89-21.

k) Definitions
As used in this Section, unless the context requires otherwise:

1) "Department" means the Illinois Department of Public Aid.

2) "Fund" means the Long-Term Care Provider Fund.

3) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

4) "Licensed nursing bed days" means, with respect to a nursing home provider, the sum for all nursing beds, with the exception of swing-beds, as described in subsection (k)(8) of this Section, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.

5) "Nursing home" means a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code;

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and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning on Title XIX of the Social Security Act.

6) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long-term care services; or a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act.

7) "Person" means, in addition to natural persons, any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

8) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

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1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3)

| Section Numbers: | Proposed Action: |
|---|---|
| 148.85 | New Section |
| 148.90 | New Section |
| 148.95 | New Section |
| 148.100 | New Section |
| 148.103 | New Section |
| 148.110 | New Section |
| 148.112 | New Section |
| 148.310 | Amendment |

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-0659

5) Complete Description of the Subjects and Issues Involved: These proposed amendments concerning hospital services are being filed pursuant to Public Act 93-0659 under which a number of new quarterly rate adjustment programs are being established to improve access to hospital services. The proposed rulemaking describes eligibility requirements and rate methodology for each rate adjustment. These new programs include:

Supplemental Tertiary Care Adjustment Payments,
Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments,
Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments,
Outpatient Rural Hospital Adjustment Payments,
Outpatient Service Adjustment Payments,
Psychiatric Base Rate Adjustment Payments, and
High Volume Adjustment Payments.

Proposed amendments to Section 148.310 add rate review provisions for each new rate adjustment program.

These rate adjustments, which are to be effective on June 1, 2004, are expected to increase expenditures for hospital services by $854.2 million during the remainder of fiscal year 2004 and fiscal year 2005.

6) Will this ruleamking replace any emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

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8) Does rulemaking contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

| Sections | Proposed Action | Illinois Register Citation |
|---|---|---|
| 148.30 | Amendment | February 6, 2004 (28 Ill. Reg. 1998) |
| 148.82 | Amendment | January 23, 2004 (28 Ill. Reg. 1350) |
| 148.150 | Amendment | March 19, 2004 (28 Ill. Reg. 4848) |
| 148.210 | Amendment | February 6, 2004 (28 Ill. Reg. 1998) |
| 148.295 | Amendment | February 27, 2004 (28 Ill. Reg. 3719) |

10) Statement of Statewide Policy Objective: These amendments do not affect units of local government.

11) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Public Aid
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002
(217)524-0081

The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

Any interested persons may review these proposed amendments on the Internet at http://www.dpaillinois.com/lawsrules/publicnotice.html. Access to the Internet is available through any local public library. In addition, the amendments may be reviewed at the Illinois Department of Human Services' local offices (except in Cook County). In Cook County, the amendments may be reviewed at the Office of the Director, Illinois Department of Public Aid, 100 West Randolph Street, Tenth Floor, Chicago, Illinois. The amendments may be reviewed at all offices Monday through Friday from 8:30 a.m. until 5:00 p.m. This notice is being provided in accordance with federal requirements at 42 CFR 447.205.

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These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded hospitals will be affected by this proposed rulemaking.

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on Which this Rulemaking Was Summarized: This rulemaking was not included on either of the 2 most rencent regulatory agendas because: This rulemaking was not anticipated by the Department when the most recent regulatory agendas were published.

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

Section
148.10 Hospital Services
148.20 Participation
148.25 Definitions and Applicability
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Services Not Covered as Hospital Services
148.70 Limitation On Hospital Services

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.85 Supplemental Tertiary Care Adjustment Payments
148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments~~Heart Transplants (Repealed)~~
148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments
148.100 Outpatient Rural Hospital Adjustment Payments~~Liver Transplants (Repealed)~~
148.103 Outpatient Service Adjustment Payments
148.105 Psychiatric Adjustment Payments
148.110 Psychiatric Base Rate Adjustment Payments~~Bone Marrow Transplants (Repealed)~~
148.112 High Volume Adjustment Payments
148.115 Rural Adjustment Payments
148.120 Disproportionate Share Hospital (DSH) Adjustments
148.122 Medicaid Percentage Adjustments
148.126 Safety Net Adjustment Payments
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Public Law 103-66 Requirements
148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a

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Population of Over Three Million
148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act
148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 Alternate Reimbursement Systems
148.210 Filing Cost Reports
148.220 Pre September 1, 1991, Admissions
148.230 Admissions Occurring on or after September 1, 1991
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 Calculation and Definitions of Inpatient Per Diem Rates
148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.285 Excellence in Academic Medicine Payments
148.290 Adjustments and Reductions to Total Payments
148.295 Critical Hospital Adjustment Payments (CHAP)
148.296 Tertiary Care Adjustment Payments
148.297 Pediatric Outpatient Adjustment Payments
148.298 Pediatric Inpatient Adjustment Payments
148.300 Payment
148.310 Review Procedure
148.320 Alternatives
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services
148.350 Definitions (Repealed)
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.368 Volume Adjustment (Repealed)
148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.390 Hearings
148.400 Special Hospital Reporting Requirements

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SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section
148.500 Definitions
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SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section
148.600 Definitions
148.610 Scope of the Program
148.620 Assistance Level and Reimbursement
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148.640 Covered Services

148.TABLE A Renal Participation Fee Worksheet
148.TABLE B Bureau of Labor Statistics Equivalence
148.TABLE C List of Metropolitan Counties by SMSA Definition

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective

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August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002;

amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004; amended at 28 Ill. Reg. ______, effective ____________.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

**Section 148.85 Supplemental Tertiary Care Adjustment Payments**

a) Qualifying Criteria. Supplemental Tertiary Care Adjustment Payments, as described in subsection (b) of this Section, shall be made to all qualifying Illinois hospitals. An Illinois hospital shall qualify for payment if it was deemed eligible for payments under the Tertiary Care Adjustment Payments for State fiscal year 2003, as described in Section 148.296, excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Supplemental Tertiary Care Adjustment Payments

1) For the supplemental tertiary care adjustment period occurring in State fiscal year 2004, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296, and shall be paid to the hospital on or before June 15, 2004.

2) For the supplemental tertiary care adjustment period occurring in State fiscal year 2005, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296 and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

c) "Supplemental Tertiary Care Adjustment Period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

d) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 28 Ill. Reg. ______, effective ____________)

**Section 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments ~~Heart Transplants (Repealed)~~**

a) Qualifying Criteria. Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments as described in subsection (b) of this Section shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).

b) MIUR Adjustment Payments

1) Each qualifying hospital will receive a payment equal to the product of:

A) The quotient of:

i) $57.25

ii) divided by the greater of the hospital's MIUR or 1.6 percent, times

B) The hospital's Medicaid inpatient days in the MIUR base period.

2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or $10,500,000.

c) Payment to a Qualifying Hospital

1) For the MIUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the MIUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

d) Definitions

1) "MIUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

2) "MIUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.

3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the MIUR base period that were adjudicated by the Department through June 30, 2002.

4) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(k)(4) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2003 shall be the MIUR used in the MIUR adjustment.

5) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

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(Source: Old Section repealed at 16 Ill. Reg. 6255, effective March 27, 1992; new Section added at 28 Ill. Reg. ______, effective ____________)

**Section 148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments**

a) Qualifying Criteria. Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments, as described in subsection (b) of this Section, shall be made to an Illinois hospital, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).

b) MOUR Adjustment Payments

1) Each qualifying hospital will receive a payment equal to the product of:

A) The quotient of:

i) the hospital's Medicaid outpatient charges in the MOUR base period

ii) divided by the greater of the hospital's MOUR or 1.6 percent, times

B) 2.45 percent.

2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

3) Payments will be the lesser of the calculation described in subsection (b)(1) or (b)(2) of this Section or $6,750,000.

c) Payment to a Qualifying Hospital

1) For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the MOUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this

Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

d) Definitions

1) "Total outpatient charges" means, for a given hospital, the gross outpatient revenue as reported on form CMS 2552-96, Worksheet G-2, Part I, row 25, column 2, for hospital fiscal years ending in calendar year 2001 filed in the March 2003 release of the Healthcare Cost Reporting Information System (HCRIS). If information was not available for hospitals on the HCRIS, the Department may obtain the gross outpatient charges from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

2) "MOUR base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

3) "MOUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.

4) "MOUR", for a given hospital, means the ratio of Medicaid outpatient charges to total outpatient charges.

5) "Medicaid outpatient charges" means, for a given hospital, the sum of charges for ambulatory procedure listing services as described in Section 148.140(b), excluding charges for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover charges), as tabulated from the Department's paid claims data for services occurring in the MOUR base year that were adjudicated by the Department through September 12, 2003.

6) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the

Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 28 Ill. Reg. ______, effective ____________)

**Section 148.100 Outpatient Rural Hospital Adjustment Payments ~~Liver Transplants (Repealed)~~**

a) Qualifying Criteria. Outpatient Rural Hospital Adjustment Payments, as described in subsection (b) of this Section, shall be made to qualifying Illinois rural hospitals, as described in Section 148.25(g)(3), excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Rural Hospital Adjustment Payments

1) Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.

2) This ratio will be multiplied by $14,500,000 to determine the hospital's Outpatient Rural Hospital Adjustment Payment.

3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

c) Payment to a Qualifying Hospital

1) For the outpatient rural hospital adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the outpatient rural hospital adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

d) Definitions

1) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

2) "Outpatient rural base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

3) "Outpatient rural adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient rural base period that were adjudicated by the Department through September 12, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Old Section repealed at 16 Ill. Reg. 6255, effective March 27, 1992; new Section added at 28 Ill. Reg. ______, effective ____________)

**Section 148.103 Outpatient Service Adjustment Payments**

a) Qualifying Criteria. Outpatient Service Adjustment Payments, as described in subsection (b) of this Section, shall be made to all Illinois hospitals excluding:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

b) Outpatient Service Adjustment Payments

1) An average hospital specific outpatient service rate for the outpatient service base period will be calculated by taking the total payments for outpatient services divided by total outpatient services.

2) The average hospital specific outpatient service rate will be multiplied by 75.5 percent and then multiplied by the outpatient services.

3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

4) Outpatient Service Adjustment Payments will be the lesser of the amount determined in subsection (b)(2) or (b)(3) of this Section or $3,000,000.

c) Payment to a Qualifying Hospital

1) For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the outpatient service adjustment period occurring in State fiscal year 2005, total annual payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

d) Definitions

1) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

2) "Outpatient service base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

3) "Outpatient service adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.

e) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 28 Ill. Reg. ______, effective ____________)

**Section 148.110 Psychiatric Base Rate Adjustment Payments~~Bone Marrow Transplants (Repealed)~~**

a) Qualifying Criteria

1) Psychiatric Base Rate Adjustment Payments, as described in subsection (b)(1) of this Section, shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding:

A) County-owned hospitals as described in Section 148.25(b)(1)(A).

B) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).

C) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

2) Psychiatric Base Rate Adjustment Payments described in subsection (b)(2) of this Section shall be made to an Illinois general acute care hospital that has a distinct part psychiatric unit, excluding hospitals described in 89 Ill. Adm. Code 140.80(j).

b) Psychiatric Base Rate Adjustment Payments

1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay an amount equal to $400.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services in effect on October 1, 2003, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period. In no event, however, shall that amount be less than zero.

2) For a hospital qualifying under subsection (a)(2) of this Section, whose inpatient psychiatric per diem rate in effect on October 1, 2003 is greater than $400.00, the Department shall pay an amount equal to $25.00 multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period.

3) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(1) or (b)(2) shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

c) Payment to a Qualifying Hospital

1) For the pychiatric base rate adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the psychiatric base rate adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

d) Limitations: Hospitals that qualify for Psychiatric Base Rate Adjustment Payments shall not be eligible for the total Psychiatric Base Rate Adjustment Payment if, during the psychiatric base rate adjustment period, the hospital no longer operates the psychiatric distinct part unit.

e) Definitions

1) "Psychiatric base rate period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

2) "Psychiatric base rate adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Medicaid inpatient psychiatric days" means, for a given hospital, the sum of days of inpatient psychiatric hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2002.

4) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Old Section repealed at 16 Ill. Reg. 6255, effective March 27, 1992; new Section added at 28 Ill. Reg. ______, effective ____________)

**Section 148.112 High Volume Adjustment Payments**

a) Qualifying criteria. High Volume Adjustment Payments shall be made to a qualifying Illinois hospital as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it did not qualify for disproportionate share adjustments as described in Section 148.120 for the rate year 2003 determination and provided more than 20,000 Medicaid inpatient days in the high volume base period.

b) The following classes of hospitals are ineligible for High Volume Adjustment Payments associated with the qualifying criteria listed in subsection (a) of this Section:

1) County-owned hospitals as described in Section 148.25(b)(1)(A).

2) Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).

3) A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).

c) High Volume Adjustment Payments

1) For a hospital qualifying under subsection (a) of this Section, the Department shall pay the product of $190.00 multiplied by the qualifying hospital's Medicaid inpatient days.

2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (c)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.

3) For hospitals qualifying under subsection (a) of this Section that provided fewer than 30,000 Medicaid inpatient days in the high volume base period, payments will be the lesser of the calculation described in subsection (c)(1) or (c)(2) of this Section or $3,500,000.

d) Payment to a Qualifying Hospital

1) For the high volume adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital on or before June 15, 2004.

2) For the high volume adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005.

e) Definitions

1) "High volume base period" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.

2) "High volume adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the high volume base period that were adjudicated by the Department through June 30, 2002.

4) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department may obtain the sum of occupied bed days from any source

available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

f) Payment Limitations: Payments under this Section are not due and payable until:

1) the methodologies described in this Section are approved by the federal government in an appropriate State Plan Amendment;

2) the assessment imposed under 89 Ill. Adm. Code 140.80 is determined to be a permissible tax under Title XIX of the Social Security Act; and

3) the assessment described in 89 Ill. Adm. Code 140.80 is in effect.

(Source: Added at 28 Ill. Reg. ______, effective ____________)

**Section 148.310 Review Procedure**

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of any rate for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs that have been mandated in order to meet State, federal or local health and safety standards, and that have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be submitted, in writing, to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its rates. Such

request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

b) Disproportionate Share (DSH) and Medicaid Percentage Adjustment (MPA) Determination Reviews

1) Hospitals shall be notified of their qualification for DSH and/or MPA payment adjustments and shall have an opportunity to request a review of the DSH and/or MPA add-on for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its disproportionate share and/or Medicaid Percentage Adjustment qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) DSH and/or MPA determination reviews shall be limited to the following:

A) DSH and/or MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. The criteria for MPA determination shall be in accordance with Section 148.122. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

B) Medicaid Inpatient Utilization Rates.

i) Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(4). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

ii) Hospitals' Medicaid inpatient utilization rates, as defined in Section 148.120(k)(4), which have been derived from unaudited cost reports or HDSC forms, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section

148.120(c)(1)(B) and (c)(1)(C)(i) and (ii), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH and/or MPA determination.

C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act, Section 148.120(a)(2) and (d), and Section 148.122(a)(2) and (c). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5 (1989) and Section 148.122(a)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30, 1992.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (Section 148.122(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.122(a)(4), (h)(2), (h)(3) and (h)(4). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

c) Outlier Adjustment Reviews
The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130, whichever is applicable. Hospitals shall be notified of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation made by the Department. Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

d) Cost Report Reviews

1) Cost reports are required from:

A) All enrolled hospitals within the State of Illinois;

B) All out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and

C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).

2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days after the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have

resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

e) Trauma Center Adjustment Reviews

1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation by the Department.

2) Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

3) Appeals under this subsection (e) must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

f) Medicaid High Volume Adjustment Reviews
The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with Section 148.120. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment

amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

g) Sole Community Hospital Designation Reviews
The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

h) Geographic Designation Reviews

1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

i) Critical Hospital Adjustment Payment (CHAP) Reviews

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

1) The Department shall make CHAP in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) CHAP determination reviews shall be limited to the following:

A) Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section 148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the federal Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.

B) Trauma level designation. Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

C) Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June

preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.

D) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

E) Graduate Medical Education Programs. Graduate Medical Education program information shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the above, substantiating that the information supplied to and utilized by the Department was incorrect.

j) Tertiary Care Adjustment Payment Reviews. The Department shall make Tertiary Care Adjustment Payments in accordance with Section 148.296. Hospitals shall be notified in writing of the results of the Tertiary Care Adjustment Payments determination and calculation, and shall have the right to appeal the Tertiary Care Adjustment Payments calculation or their ineligibility for Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

k) Pediatric Outpatient Adjustment Payment Reviews~~Payments~~. The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section

148.297. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.297 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.297 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

l) Pediatric Inpatient Adjustment Payment ReviewsPayments. The Department shall make Pediatric Inpatient Adjustment payments in accordance with Section 148.298. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.298 if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.298 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

m) Safety Net Adjustment Payment Reviews. The Department shall make Safety Net Adjustment Payments in accordance with Section 148.126. Hospitals shall be notified in writing of the results of the Safety Net Adjustment Payment determination and calculation, and shall have the right to appeal the Safety Net Adjustment Payment calculation or their ineligibility for Safety Net Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department’s notice to the hospital of its qualification for Safety Net Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify

the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

n) Psychiatric Adjustment Payment Reviews. The Department shall make Psychiatric Adjustment Payments in accordance with Section 148.105. Hospitals shall be notified in writing of the results of the Psychiatric Adjustment Payments determination and calculation, and shall have a right to appeal the Psychiatric Adjustment Payments calculation or their ineligibility for Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

o) Rural Adjustment Payment Reviews. The Department shall make Rural Adjustment Payments in accordance with Section 148.115.

1) Hospitals shall be notified in writing of the results of the Rural Adjustment Payments determination and calculation, and shall have a right to appeal the Rural Adjustment Payments calculation or their ineligibility for Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department.

2) The designation of Critical Access Provider or Necessary Provider, which are qualifying criteria for Rural Adjustment Payments (see Section 148.115(a)), is obtained from the Illinois Department of Public Health (IDPH) as of the first day of July preceding the Rural Adjustment Payment rate period. Review shall be limited to requests accompanied by documentation from IDPH, substantiating that the information supplied to and utilized by the Department was incorrect.

3) The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rural Adjustment Payments. Such a request

must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

p) Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.85. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

q) Medicaid Inpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Inpatient Utilization Rate Adjustment Payments in accordance with Section 148.90. Hospitals shall be notified in writing of the results of the Medicaid Inpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Inpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Inpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Inpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Inpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

r) Medicaid Outpatient Utilization Rate Adjustment Payment Reviews. The Department shall make Medicaid Outpatient Utilization Rate Adjustment Payments in accordance with Section 148.95. Hospitals shall be notified in writing of the results of the Medicaid Outpatient Utilization Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Outpatient Utilization Rate Adjustment Payments calculation or their ineligibility for Medicaid Outpatient Utilization Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Outpatient Utilization Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Outpatient Utilization Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

s) Outpatient Rural Hospital Adjustment Payment Reviews. The Department shall make Outpatient Rural Adjustment Payments in accordance with Section 148.100. Hospitals shall be notified in writing of the results of the Outpatient Rural Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Rural Adjustment Payments calculation or their ineligibility for Outpatient Rural Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

t) Outpatient Service Adjustment Payment Reviews. The Department shall make Outpatient Service Adjustment Payments in accordance with Section 148.103. Hospitals shall be notified in writing of the results of the Outpatient Service Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Service Adjustment Payments calculation or their ineligibility for Outpatient Service Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The

appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Service Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Service Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

u) Psychiatric Base Rate Adjustment Payment Reviews. The Department shall make Psychiatric Base Rate Adjustment Payments in accordance with Section 148.110. Hospitals shall be notified in writing of the results of the Psychiatric Base Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Base Rate Adjustment Payments calculation or their ineligibility for Psychiatric Base Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Base Rate Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Base Rate Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

v) High Volume Adjustment Payment Reviews. The Department shall make High Volume Adjustment Payments in accordance with Section 148.112. Hospitals shall be notified in writing of the results of the High Volume Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the High Volume Adjustment Payments calculation or their ineligibility for High Volume Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for High Volume Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

w)~~p)~~ For purposes of this Section, the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.

x)~~q)~~ The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.

(Source: Amended at 28 Ill. Reg. ______, effective ____________)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Illinois Plumbing Code

2) Code Citation: 77 Ill. Adm. Code 890

3) 

| Section Numbers: | Proposed Action: |
|---|---|
| 890.APPENDIX E | |
| 890.ILLUSTRATION E | Repeal |
| 890.ILLUSTRATION F | Repeal |

4) Statutory Authority: Authorized by and implementing Section 35 of the Illinois Plumbing License Law [225 ILCS 320/35].

5) A Complete Description of the Subjects and Issues Involved: The Illinois Plumbing Code includes approximately 120 illustrations intended for use in conjunction with the substantive rules of the Illinois Plumbing Code. This rulemaking repeals two illustrations, Appendix E, Illustrations E and F to correspond with changes to Section 890.540 and Section 890.550. The substantive changes resulting in the repeal of the two illustrations were made in a previous rulemaking amending the Illinois Plumbing Code. These revisions were approved by the Plumbing Code Advisory Council, as required by Section 35 of the Illinois Plumbing License Law.

   It should be noted that all of the hand-drawn illustrations currently used in the Illinois Plumbing Code are being replaced with computer-generated illustrations that more clearly represent the code requirements being illustrated. Although these new drawings will not be shown in this rulemaking, copies of the illustrations may be obtained from the Illinois Department of Public Health by contacting Susan Meister, Division of Legal Services, Illinois Department of Public Health at 217-782-2043 or via e-mail rules@idph.state.il.us.

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

7) Does this Rulemaking Contain an Automatic Repeal Date? No

8) Does this Rulemaking Contain any Incorporations by Reference? No

9) Are there any Other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand any state mandates on units of local government.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

11) Time, Place and Manner in which Interested Persons May Comment on this Rulemaking: Written or e-mail comments may be submitted within 45 days after this issue of the *Illinois Register* to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
217-782-2043
(E-mail: rules@idph.state.il.us)

This rulemaking may have an impact on small businesses. Small businesses commenting on this rulemaking shall indicate their status as such, in writing, in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses, Small Municipalities, and Not-For-Profit Corporations Affected: Licensed Plumbers and apprentice plumbers.

B) Reporting, Bookkeeping or Other Procedures Required for Compliance: There are no reporting requirements. Licensed plumbers and apprentice plumbers will have to become familiar with changes on the Plumbing Code.

C) Types of Professional Skills Necessary for Compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: January 2004

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER r: WATER AND SEWAGE

PART 890
ILLINOIS PLUMBING CODE

SUBPART A: DEFINITIONS AND GENERAL REGULATIONS

Section
890.110 General Regulations
890.120 Definitions
890.130 Incorporation by Reference
890.140 Repairs and Alterations
890.150 Workmanship
890.160 Used Plumbing Material, Equipment, Fixtures
890.170 Sewer and/or Water Required
890.180 Sewer and Water Pipe Installation
890.190 Piping Measurements
890.200 Operation of Plumbing Equipment

SUBPART B: PLUMBING MATERIALS

Section
890.210 Materials
890.220 Identification (Repealed)
890.230 Safe Pan Material and Construction

SUBPART C: JOINTS AND CONNECTIONS

Section
890.310 Tightness
890.320 Types of Joints
890.330 Special Joints
890.340 Use of Joints
890.350 Unions
890.360 Water Closet and Pedestal Urinal
890.370 Prohibited Joints and Connections in Drainage Systems
890.380 Increasers and Reducers

SUBPART D: TRAPS AND CLEANOUTS

Section
890.410 Traps
890.420 Pipe Cleanouts
890.430 Cleanout Equivalent
890.440 Acid-Proof Traps

SUBPART E: INTERCEPTORS-SEPARATORS AND BACKWATER VALVES

Section
890.510 Grease Interceptor Requirements
890.520 Gasoline, Oil and Flammable Liquids
890.530 Special Waste Interceptors
890.540 Laundries (Repealed)
890.550 Backwater Valves − Sanitary System and Storm System (Repealed)

SUBPART F: PLUMBING FIXTURES

Section
890.610 General Requirements − Material and Design
890.620 Overflows
890.630 Installation
890.640 Prohibited Fixtures
890.650 Water Closets
890.660 Urinals
890.670 Strainers and Fixture Outlets
890.680 Lavatories
890.690 Shower Receptors and Compartments
890.700 Sinks
890.710 Food Waste Disposal Units
890.720 Drinking Fountains
890.730 Floor Drains/Trench Drains
890.740 Kidney Dialysis Machines
890.745 Dental Units
890.750 Whirlpool Bathtubs
890.760 Pressure Type Water Treatment Units
890.770 Dishwashing Machines
890.780 Garbage Can Washers
890.790 Laundry Trays/Sinks and Drains

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

890.800 Special Fixtures and/or Items Designed for a Particular Purpose
890.810 Minimum Number of Plumbing Fixtures
890.820 Outside Kiosks Serving Food

SUBPART G: HANGERS, ANCHORS AND SUPPORTS

Section

890.910 Hangers, Anchors and Supports
890.920 Vertical Piping
890.930 Horizontal Piping

SUBPART H: INDIRECT WASTE PIPING, SPECIAL WASTE

Section

890.1010 Indirect Waste Piping
890.1020 Material and Size
890.1030 Length and Grade
890.1040 Air Gaps
890.1050 Receptors
890.1060 Special Wastes and Chemical Wastes

SUBPART I: WATER SUPPLY AND DISTRIBUTION

Section

890.1110 Quality of Water Supply
890.1120 Color Code
890.1130 Protection of Potable Water
890.1140 Special Applications and Installations
890.1150 Water Service Pipe Installation
890.1160 Potable Water Pumping and Storage Equipment
890.1170 Potable Water Supply Tanks and Auxiliary Pressure Tanks
890.1180 Flushing/Disinfection of Potable Water System
890.1190 Water Supply Control Valves and Meter
890.1200 Water Service Sizing
890.1210 Design of a Building Water Distribution System
890.1220 Hot Water Supply and Distribution
890.1230 Safety Devices
890.1240 Miscellaneous

SUBPART J: DRAINAGE SYSTEM

Section
890.1310 Materials
890.1320 Drainage System Installation
890.1330 Drainage Fixture Units (D.F.U.)
890.1340 Determination of Sizes for Drainage System
890.1350 Offsets in Drainage Piping
890.1360 Sanitary Wastes Below Sewer
890.1370 Floor Drains
890.1380 Storm Water Drainage Within a Building

SUBPART K: VENTS AND VENTING

Section
890.1410 Materials
890.1420 Stack Vents, Vent Stacks, Main Vents
890.1430 Vent Terminals
890.1440 Vent Terminal Size
890.1450 Vent Grades and Connections
890.1460 Fixtures Back-to-Back
890.1470 Fixture Trap Vents
890.1480 Types of Fixture Trap Vents
890.1490 Installation of Vents for Fixture Traps
890.1500 Installation of Wet Venting
890.1510 Stack Venting
890.1520 Circuit and Loop Venting
890.1530 Pneumatic Ejectors
890.1540 Relief Vents
890.1550 Offsets at an Angle Less than 45 Degrees~~°~~ from the Horizontal in Buildings of Five~~5~~ or More Stories
890.1560 Main Vents to Connect at Base
890.1570 Vent Headers
890.1580 Size and Length of Vents
890.1590 Combination Waste and Vent (Floor and Hub Drains Only)
890.1600 Special Venting for Island Fixtures

SUBPART L: PLUMBING SYSTEMS/CORRECTIONAL FACILITIES

Section
890.1710 General Requirements

890.1720 Water Closets
890.1730 Urinals
890.1740 Combination Lavatory/Toilet
890.1750 Service Sinks/Lavatory
890.1760 Sinks
890.1770 Cabinet Showers
890.1780 Flush Valves
890.1790 Soap Dishes
890.1800 Floor Drains

SUBPART M: INSPECTIONS, TESTS, MAINTENANCE, AND ADMINISTRATION

Section

890.1910 Inspections
890.1920 Testing of Plumbing Systems
890.1930 Test Methods
890.1940 General Administration
890.1950 Violations

890.APPENDIX A Plumbing Materials, Equipment, Use Restrictions and Applicable Standards
890.TABLE A Approved Materials and Standards
890.TABLE B Minimum Number of Plumbing Fixtures
890.TABLE C Minimum Air Gaps for Plumbing Fixtures
890.TABLE D Minimum Water Distribution Pipe Size
890.TABLE E Drainage Fixture Units (D.F.U.) Per Fixture Group
890.TABLE F Fixtures Not Listed in Table E
890.TABLE G Building Drains
890.TABLE H Horizontal Fixture Branches and Stacks
890.TABLE I Allowed Distance from Fixture Trap to Vent
890.TABLE J Size of Vent Stacks
890.TABLE K Size and Length of Vents
890.TABLE L Horizontal Circuit and Loop Vent Sizing Table
890.TABLE M Load Values Assigned to Fixtures
890.TABLE N Water Supply Fixture Units (W.S.F.U.) for a Supply System with Flush Tanks
890.TABLE O Water Supply Fixture Units (W.S.F.U.) for a Supply System with Flushometer
890.TABLE P Demand at Individual Water Outlets
890.TABLE Q Allowance in Equivalent Length of Pipe for Friction Loss in

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Valves and Fittings
890.APPENDIX B Illustrations for Subpart A
890.ILLUSTRATION A Air Gap Drawing #1
890.ILLUSTRATION B Air Gap Drawing #2
890.ILLUSTRATION C Battery of Fixtures
890.ILLUSTRATION D Branch
890.ILLUSTRATION E Branch Vent
890.ILLUSTRATION F Building Drain
890.ILLUSTRATION G Building Sub-drain
890.ILLUSTRATION H Circuit Vent
890.ILLUSTRATION I Common Vent
890.ILLUSTRATION J Continuous Vent
890.ILLUSTRATION K Dead End
890.ILLUSTRATION L Drain
890.ILLUSTRATION M Fixture Drain
890.ILLUSTRATION N Flush Valve (Repealed)
890.ILLUSTRATION O Grade
890.ILLUSTRATION P Horizontal Branch
890.ILLUSTRATION Q Main Vent
890.ILLUSTRATION R Quarter Bend (Repealed)
890.ILLUSTRATION S Relief Vent
890.ILLUSTRATION T Return Offset (Repealed)
890.ILLUSTRATION U Revent Pipe
890.ILLUSTRATION V Stack Vent
890.ILLUSTRATION W Trap
890.ILLUSTRATION X Vent Stack
890.ILLUSTRATION Y Wet Vent
890.ILLUSTRATION Z Yoke Vent
890.ILLUSTRATION AA Sleeves
890.APPENDIX C Illustrations for Subpart C
890.ILLUSTRATION A Caulked Joints
890.ILLUSTRATION B Flared Joints
890.ILLUSTRATION C Positions of Application for Compression Type Joints
890.APPENDIX D Illustrations for Subpart D
890.ILLUSTRATION A Fixture Traps
890.ILLUSTRATION B Distance of Trap to Fixture
890.ILLUSTRATION C Types of Traps
890.ILLUSTRATION D Trap Cleanouts
890.ILLUSTRATION E Prohibited Traps
890.ILLUSTRATION F Underground Drainage

890.ILLUSTRATION G Concealed Piping
890.ILLUSTRATION H Cleanout Clearance
890.APPENDIX E Illustrations for Subpart E
890.ILLUSTRATION A Grease Interceptor
890.ILLUSTRATION B Typical Grease Interceptor/Catch Basin
890.ILLUSTRATION C Interceptor/Separator Vents
890.ILLUSTRATION D Interceptors for Bottling Plants (Repealed)
890.ILLUSTRATION E Laundry Interceptors (Repealed)
890.ILLUSTRATION F Backwater Valve Location (Repealed)
890.APPENDIX F Illustrations for Subpart F
890.ILLUSTRATION A Prohibited Fixtures
890.ILLUSTRATION B Circular Wash Sinks
890.ILLUSTRATION C Commercial Type Grinder #1 (Repealed)
890.ILLUSTRATION D Commercial Type Grinder #2
890.ILLUSTRATION E Protective Guard
890.ILLUSTRATION F Trap and Strainer
890.APPENDIX G Illustrations for Subpart G
890.ILLUSTRATION A Cast Iron Soil Pipe Support #1
890.ILLUSTRATION B Cast Iron Soil Pipe Support #2
890.ILLUSTRATION C Horizontal Piping Support (Repealed)
890.ILLUSTRATION D Cast Iron Soil Stack Support (Repealed)
890.APPENDIX H Illustrations for Subpart H
890.ILLUSTRATION A Indirect Waste Piping #1
890.ILLUSTRATION B Indirect Waste Piping #2
890.ILLUSTRATION C Indirect Waste Piping #3
890.ILLUSTRATION D Indirect Waste Piping #4
890.ILLUSTRATION E Indirect Waste Connection
890.ILLUSTRATION F Air Gaps
890.APPENDIX I Illustrations for Subpart I
890.ILLUSTRATION A Cross Connection #1
890.ILLUSTRATION B Cross Connection #2
890.ILLUSTRATION C Cross Connection #3
890.ILLUSTRATION D Flushometer Valve
890.ILLUSTRATION E Underground Water Piping #1
890.ILLUSTRATION F Underground Water Piping #2
890.ILLUSTRATION G Underground Water Piping #3
890.ILLUSTRATION H Water Supply Control
890.ILLUSTRATION I Shut-Off Valve at Meter
890.ILLUSTRATION J Separate Controls for Each Family Unit
890.ILLUSTRATION K Shut-Off Valves in Buildings Other Than Dwellings

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890.ILLUSTRATION L Typical Gas Water Heater
890.ILLUSTRATION M Typical Electric Water Heater
890.ILLUSTRATION N P & T Valve Installed in Hot Outlet Line
890.ILLUSTRATION O P & T Relief Valve
890.APPENDIX J Illustrations for Subpart J
890.ILLUSTRATION A Dead Ends
890.ILLUSTRATION B Horizontal to Vertical Change of Direction
890.ILLUSTRATION C Horizontal to Horizontal Change of Direction
890.ILLUSTRATION D Vertical to Horizontal Change of Direction
890.ILLUSTRATION E Fixture Connections
890.ILLUSTRATION F Waste Stacks
890.ILLUSTRATION G Offsets on Drainage Piping
890.ILLUSTRATION H Relief Vent
890.ILLUSTRATION I Above Highest Branch
890.ILLUSTRATION J Below Lowest Branch
890.ILLUSTRATION K Drainage Below Sewer Level
890.ILLUSTRATION L Sanitary Wastes Below Sewer
890.APPENDIX K Illustrations for Subpart K
890.ILLUSTRATION A Installation of Vent Stack or Main Vent
890.ILLUSTRATION B Terminal
890.ILLUSTRATION C Main Stack
890.ILLUSTRATION D Roof Garden
890.ILLUSTRATION E Location of Vent Terminal
890.ILLUSTRATION F Grade
890.ILLUSTRATION G Vertical Rise
890.ILLUSTRATION H Height Above Fixtures
890.ILLUSTRATION I Quarter Bends
890.ILLUSTRATION J Heel or Side-Inlet
890.ILLUSTRATION K Fixtures Back-to-Back and Side-by-Side
890.ILLUSTRATION L Distance from Trap to Vent
890.ILLUSTRATION M Trap Weir
890.ILLUSTRATION N Trap Vent
890.ILLUSTRATION O Common Vent
890.ILLUSTRATION P Wet Vent
890.ILLUSTRATION Q Vertical Wet Vent
890.ILLUSTRATION R Hydraulic Gradient
890.ILLUSTRATION S Single Bathroom Groups
890.ILLUSTRATION T Double Bath
890.ILLUSTRATION U Multistory Bathroom Groups − Plan
890.ILLUSTRATION V Multistory Bathroom Groups − Elevation

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| | |
|---|---|
| 890.ILLUSTRATION W | One Bathroom Group − Plan |
| 890.ILLUSTRATION X | One Bathroom Group − Elevation |
| 890.ILLUSTRATION Y | Battery Venting |
| 890.ILLUSTRATION Z | Dual Branches |
| 890.ILLUSTRATION AA | Right and Wrong Vent Connections |
| 890.ILLUSTRATION BB | Fixtures Back-to-Back in Battery |
| 890.ILLUSTRATION CC | Fixture Connections − Offset Vents |
| 890.ILLUSTRATION DD | Circuit Vented Fixtures |
| 890.ILLUSTRATION EE | Main Vents |
| 890.ILLUSTRATION FF | Combination Waste and Vent |
| 890.ILLUSTRATION GG | Special Venting for Island Fixtures |

AUTHORITY: Implementing and authorized by Section 35 of the Illinois Plumbing License Law [225 ILCS 320/35].

SOURCE: Filed August 20, 1969; amended at 7 Ill. Reg. 4245, effective March 24, 1983; emergency amendment at 7 Ill. Reg. 7328, effective May 31, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 13930, effective October 12, 1983; codified at 8 Ill. Reg. 19993; amended at 8 Ill. Reg. 24621, effective December 12, 1984; amended at 9 Ill. Reg. 13340, effective August 21, 1985; amended at 10 Ill. Reg. 7862, effective May 16, 1986; amended at 11 Ill. Reg. 9278, effective April 30, 1987; amended at 14 Ill. Reg. 1385, effective January 10, 1990; Part repealed, new Part adopted at 17 Ill. Reg. 21516, effective December 1, 1993; emergency amendment at 18 Ill. Reg. 14444, effective September 1, 1994, for a maximum of 150 days; emergency expired January 28, 1995; amended at 22 Ill. Reg. 21540, effective December 1, 1998; amended at 28 Ill. Reg. 4215, effective February 18, 2004; amended at 28 Ill. Reg. ______, effective ____________.

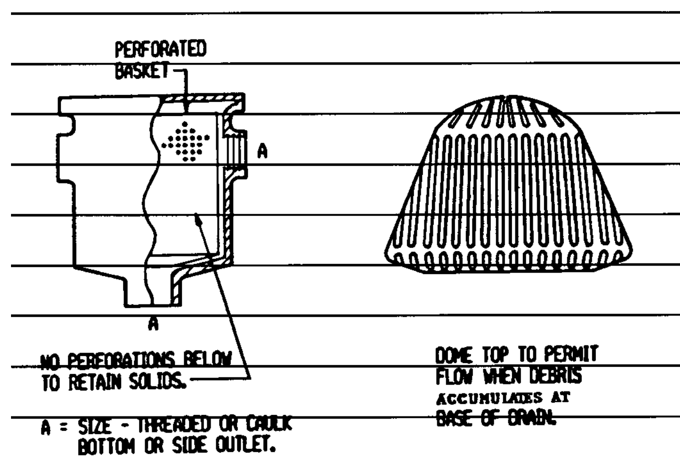
DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

**Section 890.APPENDIX E Illustrations for Subpart E**

**Section 890.ILLUSTRATION E Laundry Interceptors (Repealed)**

~~(Referenced in Section 890.540)~~




(Source: Repealed at 28 Ill. Reg. ______, effective ____________)

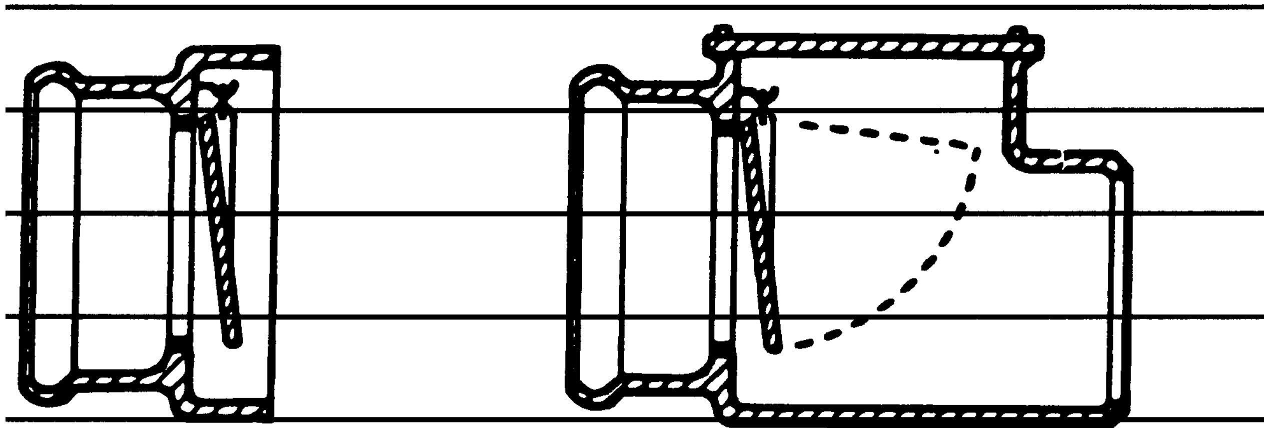
DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

**Section 890.APPENDIX E Illustrations for Subpart E**

**Section 890.ILLUSTRATION F Backwater Valve Location (Repealed)**

~~(Referenced in Section 890.550(c))~~



(Source: Repealed at 28 Ill. Reg. ______, effective ____________)

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Medical Practice Act of 1987

2) Code Citation: 68 Ill. Adm. Code 1285

3)

| Section Numbers: | Adopted Action: |
|---|---|
| 1285.40 | Amendment |
| 1285.60 | Amendment |
| 1285.100 | Amendment |
| 1285.110 | Amendment |
| 1285.130 | Amendment |

4) Statutory Authority: Medical Practice Act of 1987 [225 ILCS 60]

5) Effective Date of amendments: March 29, 2004

6) Does this rulemaking contain an automatic repeal date? No

7) Do these amendments contain incorporations by reference? No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Date Notice of Proposal Published in Illinois Register: October 31, 2003, at 27 Ill. Reg. 16362.

10) Has JCAR issued a Statement of Objection to these amendments? No

11) Differences between proposal and final version: No substantive differences.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these amendments replace any emergency amendments currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Amendments: Amends Section 1285.60 relating to the National Board of Chiropractic Examiners examination to change the passing score to reflect changes made at the national level. Amends Section 1285.100 to require, as a condition for licensure as a visiting professor, that the applicant "has and maintains"

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

professor status in another jurisdiction rather than merely having held that status previously. Section 1285.110 is amended to clarify that CME waivers may be granted for temporary, rather than chronic, incapacitating illness, and clarifies in 1285.130 that restorations beyond 3 years also require proof of 150 CME hours. Includes other technical and clean-up changes.

16) Information and questions regarding these adopted amendments shall be directed to:

Department of Professional Regulation
Attention: Barb Smith
320 West Washington, 3rd Floor
Springfield, Illinois 62786
217/785-0813 Fax: 217/782-7645

The full text of the adopted amendments begins on the next page:

DEPARTMENT OF PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

TITLE 68: PROFESSIONS AND OCCUPATIONS
CHAPTER VII: DEPARTMENT OF PROFESSIONAL REGULATION
SUBCHAPTER b: PROFESSIONS AND OCCUPATIONS

PART 1285
MEDICAL PRACTICE ACT OF 1987

SUBPART A: MEDICAL LICENSING, RENEWAL
AND RESTORATION PROCEDURE

Section
1285.20 Six (6) Year Post-Secondary Programs of Medical Education
1285.30 Programs of Chiropractic Education
1285.40 Approved Postgraduate Training Programs
1285.50 Application for Examination
1285.60 Examinations
1285.70 Application for a License on the Basis of Examination
1285.80 Licensure by Endorsement
1285.90 Temporary Licenses
1285.91 Visiting Resident Permits
1285.95 Professional Capacity Standards for Applicants Having Graduated More Than 2 Years Prior to Application
1285.100 Visiting Professor Permits
1285.101 Visiting Physician Permits
1285.105 Chiropractic Physician Preceptorship (Repealed)
1285.110 Continuing Medical Education (CME)
1285.120 Renewals
1285.130 Restoration and Inactive Status
1285.140 Granting Variances

SUBPART B: MEDICAL DISCIPLINARY PROCEEDINGS

Section
1285.200 Medical Disciplinary Board
1285.205 Complaint Committee
1285.210 The Medical Coordinator
1285.215 Complaint Handling Procedure
1285.220 Informal Conferences
1285.225 Consent Orders
1285.230 Summary Suspension

1285.235 Mandatory Reporting of Impaired Physicians by Health Care Institutions
1285.240 Standards
1285.245 Advertising
1285.250 Monitoring of Probation and Other Discipline and Notification
1285.255 Rehabilitation
1285.260 Fines
1285.265 Subpoena Process of Medical and Hospital Records
1285.270 Inspection of Physical Premises
1285.275 Failing to Furnish Information

SUBPART C: GENERAL INFORMATION

Section
1285.310 Public Access to Records and Meetings
1285.320 Response to Hospital Inquiries
1285.330 Rules of Evidence
1285.335 Physician Delegation of Authority
1285.340 Anesthesia Services in an Office Setting

AUTHORITY: Implementing the Medical Practice Act of 1987 [225 ILCS 60] and authorized by Section 2105-15(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/2105-15(7)].

SOURCE: Adopted at 13 Ill. Reg. 483, effective December 29, 1988; emergency amendment at 13 Ill. Reg. 651, effective January 1, 1989, for a maximum of 150 days; emergency expired May 31, 1989; amended at 13 Ill. Reg. 10613, effective June 16, 1989; amended at 13 Ill. Reg. 10925, effective June 21, 1989; emergency amendment at 15 Ill. Reg. 7785, effective April 30, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 13365, effective September 3, 1991; amended at 15 Ill. Reg. 17724, effective November 26, 1991; amended at 17 Ill. Reg. 17191, effective September 27, 1993; expedited correction at 18 Ill. Reg. 312, effective September 27, 1993; amended at 20 Ill. Reg. 7888, effective May 30, 1996; amended at 22 Ill. Reg. 6985, effective April 6, 1998; amended at 22 Ill. Reg. 10580, effective June 1, 1998; amended at 24 Ill. Reg. 3620, effective February 15, 2000; amended at 24 Ill. Reg. 8348, effective June 5, 2000; amended at 26 Ill. Reg. 7243, effective April 26, 2002; amended at 28 Ill. Reg. 5857, effective March 29, 2004.

SUBPART A: MEDICAL LICENSING, RENEWAL AND RESTORATION PROCEDURE

**Section 1285.40 Approved Postgraduate Clinical Training Programs**

a) A hospital shall, in the judgment of the Department, be deemed approved for the

post-graduate clinical training ("clinical training") required for licensure if it meets the following standards:

1) Contains at least the departments of internal medicine, surgery, obstetrics and pediatrics; and has an organized departmentalized staff, holding meetings monthly for case reviews and study.

2) Laboratory employing a full-time technician and at least a part-time pathologist legally empowered to perform laboratory services, visiting the laboratory at least 2 days per week.

3) Radiological department employing an X-ray technician and at least a part-time roentgenologist legally empowered to perform radiology services, visiting the department at least 2 days per week.

4) Maintenance of an up-to-date medical library available to residents.

b) The hospital shall, upon request, provide the Department with the names of staff members of the various departments of the hospital.

c) The hospital shall certify, on forms provided by the Department, to the satisfactory completion of not less than 12 months of clinical training as required by Section 11(A)(1) of the Act or 24 months of clinical training as required by Section 11 (A)(2) and (3). Such certification shall identify the commencement date and the concluding date of the training.

d) The Department, upon the recommendation of the Medical Licensing Board, has determined that all clinical training programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the Federation of Medical Licensing Authorities of Canada as of January 1, 1999, meet the minimum criteria set forth in this Section and are, therefore, approved, except as provided in subsection (e).

e) In the event of a decision by any of the above accrediting bodies in subsection (d) to suspend, withdraw or revoke accreditation of any clinical training, the Board shall proceed to evaluate the program and either approve or disapprove the program pursuant to the minimum criteria set out in subsection (a) ~~above~~.

(Source: Amended at 28 Ill. Reg. 5857, effective March 29, 2004)

**Section 1285.60 Examinations**

a) Examinations for licensure to practice medicine in all of its branches:

1) Examinations conducted by the Department or its designated testing service for licensure to practice medicine in all of its branches shall be conducted in the English language and shall, prior to December 31, 1993, consist of:

A) The Federation Licensing Examination − FLEX Component 1 – an examination placing emphasis on basic and clinical science principles and mechanisms underlying high-impact diseases and problems encountered in an in-patient, supervised setting, during the delivery of health care; and

B) The Federation Licensing Examination − FLEX Component 2 – emphasis on issues related to the general delivery of health care to patients in an ambulatory setting encountered in an independent practice.

2) For those applicants who have passed FLEX Component 2 but have not successfully completed FLEX Component 1 prior to 1994, the Department shall administer FLEX Component 1 twice in 1994. Any applicant who does not successfully complete FLEX Component 1 during 1994 shall be required to successfully complete USMLE Step 1 and Step 2 in accordance with this Section.

3) Beginning January 1, 1994, the examinations for licensure to practice medicine in all of its branches shall be Steps 1, 2 and 3 of the United State Medical Licensing Examination (USMLE) − a joint program of the Federation of State Medical Boards of the United States Inc. and the National Board of Medical Examiners.

A) USMLE Step 1 and Step 2 will be administered by the National Board of Medical Examiners and the Education Commission for Foreign Medical Graduates (ECFMG).

B) USMLE Step 3 will be administered by the Department or its designated testing service. Examinees shall successfully complete

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Step 1 and Step 2 before applying to the Department to take Step 3 of the examination.

4) The Department will accept the following combinations of examinations completed prior to January 1, 2000:

A) FLEX Component 1 taken prior to January 1, 1995, and FLEX Component 2 taken prior to January 1, 1994;

B) FLEX Component 1 plus USMLE Step 3;

C) National Board of Medical Examiners (NBME) Part 1 or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component 2; or

D) NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3.

5) The passing score on all Components, Parts or Steps of the examinations set forth in subsections (a)(2), (3) and (4) ~~above~~ shall be a minimum of 75 or the passing score set by the authorized testing entity.

6) In the case of failure on the examination, examinees shall be required to retake only that Component, Part or Step of the examination on which they did not achieve a passing score.

7) In the event all USMLE Steps are not successfully completed within 7 years after passing the first step taken, either Step 1 or Step 2, credit for any Step passed shall be forfeited.

8) Any applicant for licensure to practice medicine in all of its branches who has been unsuccessful in 5 examinations (any Component, Part or Step of the examinations accepted by the Department as set forth in subsection (a)(4)), conducted in this State or any other jurisdiction shall be deemed ineligible for further examination and/or licensure until the Department is in receipt of proof that the applicant has completed, subsequent to his/her fifth failure:

A) a course of clinical training of not less than 12 months in an accredited clinical training program in the United States or Canada

in accordance with Section 1285.40; or

B) a course of study of 9 months in length (one academic year) which includes no less than 25 clock hours per week of basic sciences as set forth in Section 1285.20(b) of this Part and no less than 40 clock hours per week of clinical sciences as set forth in Section 1285.20(d) of this Part; or

C) any other formal professional study or training in an accredited medical college or hospital, deemed by the Department to meet the requirements of subsection (a)(8) (A) or (B).

9) Failure to appear for any Component, Part or Step of the examination for which the applicant has been scheduled shall be considered a failure of the examination.

b) Examinations for licensure to practice chiropractic.

1) Examinations for licensure to practice chiropractic shall be conducted in the English language and shall consist of the examination administered by the National Board of Chiropractic Examiners and shall consist of Part I, Part II and Part III.

2) To be successful, examinees must receive a score of at least 375~~75~~ on all 3 parts of the examination.

3) Any applicant for licensure as a chiropractic physician who has been unsuccessful in 5 examinations conducted in this State or any other jurisdiction shall be deemed ineligible for further examination or licensure until the Department is in receipt of proof (i.e., certificate of completion of training, transcript) that the applicant has completed, subsequent to his/her fifth failure, a course of study of 960 classroom hours (one academic year) in an accredited chiropractic program or any other equivalent formal professional study or training in an accredited chiropractic program as approved by the Department.

(Source: Amended at 28 Ill. Reg. 5857, effective March 29, 2004)

**Section 1285.100 Visiting Professor Permits**

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a) Any person not licensed in this State to practice medicine in all of its branches or as a chiropractic physician who has been appointed as a visiting professor at a medical, osteopathic or chiropractic program (program of medicine) in this State must be the holder of a Visiting Professor Permit issued by the Department pursuant to the provisions of Section 18 of the Act.

b) An application for a Visiting Professor Permit shall be made on forms provided by the Department. The application shall include:

1) The name and location of the applicant's program of medicine, dates of attendance, date and type of degree conferred;

2) Certification from the jurisdiction of original licensure indicating:

A) The date of issuance and status of the license; and

B) Whether the records of the licensing authority contain any record of any disciplinary action or pending action;

3) Verification, signed by a dean of a program of medicine located in another jurisdiction, that the applicant was qualified and has and maintains ~~held~~ professor status in the program;

4) Certification from the Dean of the program of medicine indicating:

A) That the entity has contracted with the applicant and the applicant has received a faculty appointment to teach in the program;

B) Name and address of the patient care clinics or facilities affiliated with the medical program at which the applicant will be providing instruction and/or providing clinical care and a justification for any clinical activities that will be provided at the facilities;

C) The nature of the educational services to be provided by the applicant and the qualifications of the applicant to provide these services;

D) The term of the contract;

5) A copy of the applicant's current curriculum vitae; and

6) The fee of $300.

c) In determining the need for the issuance of a Visiting Professor Permit, the Department, upon the recommendation of the Medical Licensing Board, shall consider the availability to the program of medicine of the services for which the Visiting Professor Permit is sought.

d) Written notice of the Department's final action on every application for a Visiting Professor Permit shall be given to the applicant and the program of medicine designated. When the application is approved, the Visiting Professor Permit shall be delivered or mailed to the program of medicine. The applicant shall not commence the faculty appointment before the program receives written notification of the approval of the application.

e) The initial Visiting Professor Permit shall be valid for 2 years or for the term of the faculty appointment, if less than 2 years. The Visiting Professor Permit may be renewed. Renewed Visiting Professor Permits shall be issued to expire on July 31 in the year of the physician license renewal. Individuals holding a valid Visiting Professor Permit on the effective date of this Section are eligible for renewal of that permit pursuant to subsection (f).

f) For the first renewal of the Visiting Professor Permit, the permit holder shall file an application with the Department, on forms provided by the Department, that includes:

1) Certification from the Dean of the program of medicine indicating the term of the renewal contract and a list of the affiliated patient care clinics and facilities where the permit holder will be providing instruction and the justification for any clinical activities that will be provided at the facilities;

2) Certification from the jurisdiction of original licensure indicating the current status of the license;

3) Proof of successful completion of:

A) the United States Medical Licensing Examination (USMLE) Step 2 or the Special Purpose Examination (SPEX) in accordance with Section 1285.60 for a visiting professor to practice medicine in all of its branches; or

B) the National Board of Chiropractic Examiners (NBCE) Part II or SPEC in accordance with Section 1285.60 for a visiting professor to practice chiropractic; and

4) The renewal fee of $300.

Renewal of a Visiting Professor Permit shall be renewed after the first initial renewal in accordance with subsection (g).

g) For renewals not made pursuant to subsection (f), the application for renewal of a Visiting Professor Permit shall be made on forms supplied by the Department at least 60 days prior to expiration of the permit. The Visiting Professor Permit renewal application shall include:

1) Certification from the Dean of the program of medicine indicating a valid contract between the visiting professor and the school and a list of the affiliated patient care clinics and facilities where the permit holder will be providing instruction and the justification for any clinical activities that will be provided at the facilities;

2) Certification from the jurisdiction of original licensure indicating the current status of the license;

3) Completion of the 150 hours continuing medical education in accordance with Section 1285.110; and

4) The renewal fee of $300.

h) When any person on whose behalf a Visiting Professor Permit has been issued shall be discharged or shall terminate his/her faculty appointment, any permit issued in the name of such person shall be null and void as of the date of discharge or termination. The program of medicine shall immediately deliver or mail by registered mail to the Department the Visiting Professor Permit and written notice of the reason for the return of the permit.

i) Only one Visiting Professor Permit shall be issued to an applicant. If the faculty appointment for which the permit was issued is terminated and the holder of the permit desires to remain in the State and practice or teach his/her profession, he/she must apply for, meet all the requirements of this State for, and receive a

license to practice that profession.

j) Whenever a program of medicine is required to deliver or return a Visiting Professor Permit to the Department and that permit has been lost or destroyed or is for any other reason unavailable for return to the Department, the program of medicine shall immediately mail or deliver to the Department a written explanation concerning the inability to return the permit.

k) When there has been a change in or addition to privileges of a visiting professor or a change in a facility where instruction or clinical care is being provided, the program shall notify the Department in writing of the changes and a justification for the changes. The Department, upon recommendation of the Licensing Board, shall review the information and determine if a new permit needs to be issued.

l) Nothing in this Section shall prohibit the holder of a Visiting Professor Permit from applying for and receiving a license to practice his/her profession in this State during the term of his/her faculty appointment. In the event the holder of a permit is issued a license to practice his/her profession in this State, upon receipt of the license, the permit shall become null and void and shall be returned to the Department pursuant to the provisions of subsection (h) ~~above~~.

m) *Persons holding a permit under this Section shall only practice medicine in all of its branches or practice the treatment of human ailments without the use of drugs and without operative surgery in the State of Illinois in their official capacity under their contract within the medical school itself and any affiliated institution in which the permit holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility.* (Section 18 of the Act)

(Source: Amended at 28 Ill. Reg. 5857, effective March 29, 2004)

**Section 1285.110 Continuing Medical Education (CME)**

*The Department shall promulgate rules of continuing education for persons licensed under the Act that require 150 hours of continuing education per license renewal cycle. These rules shall be consistent with requirements of relevant professional associations, specialty societies, or boards. The rules shall also address variances for illness or hardship. In establishing these rules, the Department shall consider educational requirements for medical staffs, requirements for specialty society board certification or for continuing education requirements as a condition of membership in societies representing the 2 categories of licensee* (physicians licensed to

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practice medicine in all of its branches and chiropractic physicians) *under the Act. These rules shall assure, but not be limited to, that licensees are given the opportunity to participate in those programs sponsored by or through their professional associations or hospitals which are relevant to their practice. Each licensee is responsible for maintaining records of completion of continuing education and shall be prepared to produce the records when requested by the Department.* (Section 20 of the Act)

a) Continuing Medical Education Hours Requirements

1) For the July 31, 1999 renewal, a licensee will be required to complete 50 hours of continuing medical education (CME). The Department will accept CME taken on or after July 1, 1997. Beginning with the July 31, 2002 renewal and every renewal thereafter, in order to renew a license, a licensee shall be required to complete 150 hours of continuing medical education per prerenewal period.

2) A prerenewal period is the 36 months preceding July 31 in the year of the renewal.

3) One CME hour shall equal one clock hour. After completion of the initial CME hour, credit may be given in one-half hour increments.

4) A renewal applicant shall not be required to comply with CME requirements for the first renewal of an Illinois license.

5) Individuals licensed in Illinois but residing and practicing in other states shall comply with the CME requirements set forth in this Section.

6) Continuing medical education credit hours used to satisfy the CME requirements of another jurisdiction may be applied to fulfill the CME requirements of the State of Illinois if the CME required by the other jurisdiction is consistent with the CME requirements set forth in this Section.

7) The Department, upon recommendation of the Medical Licensing Board, will accept the American Medical Association Physician Recognition Award (AMA PRA) certificate awarded to physicians licensed to practice medicine in all of its branches as documentation of compliance with the 150 CME hours set forth in this Part. The hours shall be earned consistently with the prerenewal period set forth in subsection (a)(2).

8) CME used to satisfy the requirements for renewal of a license may not be used to satisfy the CME requirements for another renewal period.

9) The CME requirements set forth in this Section apply to both physicians licensed to practice medicine in all of its branches and chiropractic physicians licensed in Illinois.

b) Continuing Medical Education (CME) hours for both physicians licensed to practice medicine in all of its branches and chiropractic physicians licensed to treat human ailments without the use of drugs and without operative surgery in Illinois shall be earned by, but not limited to, verified attendance at (e.g., certificate of attendance or certificate of completion) or participation in a program or course (program) as follows:

1) CME hours shall be earned as follows:

A) A minimum of 60 hours of required CME shall be obtained in formal CME programs set forth in subsection (b)(2);

B) A maximum of 90 hours of the required CME shall be obtained in informal CME programs or activities as set forth in subsection (b)(3).

2) Formal CME Programs:

A) Formal programs conducted or endorsed by hospitals, specialty societies, facilities or other organizations approved to offer CME credit as set forth in subsection (c).

B) Formal CME programs conducted by medical, chiropractic or osteopathic colleges, schools or education programs, including the Accreditation Council for Graduate Medical Education, the Council on Continuing Medical Education of the American Osteopathic Association or the Commission on Accreditation of the Council of Chiropractic Education schools, either to prepare individuals for licensure pursuant to the provisions of the Act or for postgraduate training.

C) CME programs required for certification or recertification by

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specialty boards and professional associations.

D) Activities which are given by sponsors approved in accordance with this Section:

i) CME utilizing materials such as CD-ROMs, printed educational materials, audiotapes, video cassettes, films, slides and computer assisted instruction that provide a clear, concise statement of the educational objectives and indicate the intended audience. These programs shall also have a method of verifying physicians' participation;

ii) Journal club activities;

iii) Self-assessment activities;

iv) Journal-based CME.

3) Informal CME programs or activities shall consist of, but not be limited to, any of the following activities that the licensee must document including the dates and a brief description of the activity:

A) Consultation with peers and experts concerning patients;

B) Use of electronic databases in patient care;

C) Small group discussions;

D) Teaching health professionals;

E) Medical writing;

F) Teleconferences;

G) Preceptorships;

H) Participating in formal peer review and quality assurance activities;

I) Preparation of educational exhibits;

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J) Journal reading.

c) CME Sponsors and Formal Programs

1) Sponsor, as used in this Section, shall mean:

A) For physicians licensed to practice medicine in all of its branches:

i) Accreditation Council on Continuing Medical Education and organizations accredited by ACCME as sponsors of CME;

ii) Illinois State Medical Society, or its affiliates;

iii) Council on Continuing Medical Education for the American Osteopathic Association and the Illinois Osteopathic Medical Society or its affiliates;

iv) Any other accredited school, college or university, State agency, or any other person, firm, or association that has been approved and authorized by the Department pursuant to subsection (c)(2) to coordinate and present continuing medical education courses and programs in conjunction with this Section.

B) For chiropractic physicians:

i) Illinois Chiropractic Society, or its affiliates;

ii) Illinois Prairie State Chiropractic Association, or its affiliates;

iii) International Chiropractic Association, or its affiliates;

iv) American Chiropractic Association, or its affiliates; or

v) Any other accredited school, college or university, State agency, or any other person, firm, or association that has been approved and authorized by the Department pursuant to subsection (c)(2) to coordinate and present continuing

medical education courses and programs in conjunction with this Section.

C) Physicians licensed to practice medicine in all of its branches or chiropractic physicians may earn CME hours from the sponsors set forth in subsections (c)(1)(A) and (B).

2) An entity, not listed in subsections (c)(1)(A) and (B), seeking approval as a CME sponsor for formal programs shall submit an application, on forms supplied by the Department, along with a $2000 nonrefundable application fee. (State agencies, State colleges and State universities in Illinois shall be exempt from paying this fee.) The application shall include:

A) Certification:

i) That all programs offered by the sponsor for CME credit shall comply with the criteria in subsection (c)(3) and all other criteria in this Section;

ii) That the sponsor shall be responsible for verifying completion of each program and provide a certificate of attendance as set forth in subsection (c)(9);

iii) That, upon request by the Department, the sponsor shall submit evidence (e.g., certificate of attendance or course material) as is necessary to establish compliance with this Section. Evidence shall be required when the Department has reason to believe that there is not full compliance with the statute and this Part and that this information is necessary to ensure compliance;

iv) That each sponsor shall submit to the Department written notice of program offerings, including program offerings of subcontractors, 30 days prior to course dates. Notice shall include the description, location, date and time of the program to be offered.

B) A copy of a sample program including course materials, syllabi and a list of faculty.

3) All formal programs shall:

A) Contribute to the advancement, extension and enhancement of the professional skills and scientific knowledge of the licensee;

B) Foster the enhancement of general or specialized practice and values;

C) Be developed and presented by persons with education and/or experience in the subject matter of the program;

D) Specify the course objectives, course content and teaching methods to be used;

E) Specify the number of CME hours that may be applied to fulfilling the Illinois CME requirements for license renewal.

4) Each CME formal program shall provide a mechanism for evaluation of the program and instructor by the participants. The evaluation may be completed on-site immediately following the program presentation or an evaluation questionnaire may be distributed to participants to be completed and returned by mail. The sponsor and the instructor, together, shall review the evaluation outcome and revise subsequent programs accordingly.

5) An approved sponsor may subcontract with individuals and organizations to provide approved programs. All advertising, promotional materials, and certificates of attendance must identify the licensed sponsor and the sponsor's license number. The presenter of the program may also be identified, but should be identified as a presenter. When a licensed sponsor subcontracts with a presenter, the licensed sponsor retains all responsibility for attendance, providing certificates of attendance and ensuring the program meets all of the criteria established by the Act and this Part, including the maintenance of records.

6) To maintain approval as a sponsor, each shall submit to the Department by July 31 in the year of renewal a renewal application, a $2000 fee and a list of courses and programs offered within the last 36 months. The list shall include a brief description, location, date and time of each course given by the sponsor and by any subcontractor.

7) Certification of Attendance. It shall be the responsibility of a sponsor to provide each participant in a program with a certificate of attendance or participation. The sponsor's certificate of attendance shall contain:

A) The name, address and license number of the sponsor;

B) The name and address of the participant;

C) A brief statement of the subject matter;

D) The number of hours attended in each program;

E) The date and place of the program;

F) The signature of the sponsor.

8) The sponsor shall maintain attendance records for not less than 5 years.

9) The sponsor shall be responsible for assuring that no renewal applicant shall receive CME credit for nonparticipation in a program.

10) Upon the failure of a sponsor to comply with any of the preceding requirements of this Section, the Department, after notice to the sponsor and hearing before and recommendation by the Board (see 68 Ill. Adm. Code 1110), shall thereafter refuse to accept for CME credit attendance at or participation in any of that sponsor's CME programs until such time as the Department receives assurances of compliance with this Section.

11) Notwithstanding any other provision of this Section, the Department or Board may evaluate any sponsor of any approved CME program at any time to ensure compliance with requirements of this Section.

d) Certification of Compliance with CME Requirements

1) Each renewal applicant shall certify, on the renewal application, full compliance with the CME requirements set forth in subsections (a) and (b).

2) The Department may require additional evidence demonstrating

compliance with the CME requirements (e.g., certificate of attendance). This additional evidence shall be required in the context of the Department's random audit. It is the responsibility of each renewal applicant to retain or otherwise produce evidence of compliance.

3) When there appears to be a lack of compliance with CME requirements, an applicant shall be notified in writing and may request an interview with the Licensing Board. At that time the Licensing Board may recommend that steps be taken to begin formal disciplinary proceedings as required by Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65].

4) The Department shall conduct a random audit to verify compliance with the CME requirements.

e) Continuing Medical Education Earned in Other Jurisdictions

1) If a licensee has earned or is seeking formal CME hours offered in another jurisdiction not given by an approved sponsor for which the licensee will be claiming credit toward full compliance in Illinois, the applicant shall submit an individual program approval request form, along with a $25 processing fee, prior to participation in the program or within 90 days prior to expiration of the license. The Licensing Board shall review and recommend approval or disapproval of the program using the criteria set forth in subsection (c)(3) of this Section.

2) If a licensee fails to submit an out of state CME approval form within the required time frame, late approval may be obtained by submitting the approval request form with the $25 processing fee plus a $100 per hour of CME late fee not to exceed $500. The Licensing Board shall review and recommend approval or disapproval of the program using the criteria set forth in subsection (c)(3) of this Section.

f) Restoration of Nonrenewed License. Upon satisfactory evidence of compliance with CME requirements, the Department shall restore the license upon payment of the required fee as provided in Section 21(e)(5) of the Act.

g) Waiver of CME Requirements

1) Any renewal applicant seeking renewal of a license without having fully

complied with these CME requirements shall file with the Department a renewal application along with the required fee set forth in Section 21(e)(4) of the Act, a statement setting forth the facts concerning non-compliance and a request for waiver of the CME requirements on the basis of these facts. A request for waiver shall be made prior to the renewal date. If the Department, upon the written recommendation of the Licensing Board, finds from such affidavit or any other evidence submitted that extreme hardship has been shown for granting a waiver, the Department shall waive enforcement of CME requirements for the renewal period for which the applicant has applied.

2) Hardship shall be determined on an individual basis by the Board and be defined as an inability to devote sufficient hours to fulfilling the CME requirements during the applicable prerenewal period because of:

A) Full-time service in the armed forces of the United States of America during a substantial part of the prerenewal period;

B) A temporaryAn incapacitating illness documented by a statement from a currently licensed physician;

C) Undue hardship (prolonged hospitalization, family illness); or

D) Any other similar extenuating circumstances.

3) Any renewal applicant who, prior to the expiration date of the license, submits a request for a waiver, in whole or in part, pursuant to the provisions of this Section shall be deemed to be in good standing until the final decision on the application is made by the Department.

(Source: Amended at 28 Ill. Reg. 5857, effective March 29, 2004)

**Section 1285.130 Restoration and Inactive Status**

a) A licensee seeking restoration of his license which has expired for 3 years or less shall have a license restored upon payment of all lapsed renewal fees required by Section 21 of the Act and proof of completion of 150 hours of continuing education in accordance with Section 1285.110.

b) A licensee seeking restoration of a license which has been placed on inactive

status for 3 years or less shall have his license restored upon payment of the current renewal fee and the continuing education requirements for the last renewal period.

c) A licensee seeking restoration of a license after it has expired or been placed on inactive status for more than 3 years shall file an application, on forms supplied by the Department, together with the fee required by Section 21 of the Act and proof of completion of 150 hours of continuing education in accordance with Section 1285.110. The licensee shall also submit one or more of the following:

1) Sworn evidence of active practice in another jurisdiction. Such evidence shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the licensee was authorized to practice during the term of active practice.

2) An affidavit attesting to military service as provided in Section 21 of the Act.

3) Proof of successful completion (evidenced by Certification of Clinical Training) of an approved specialty residency program of at least 12 twelve months in length within 3 three years from the date of application.

4) Proof of completion evidenced by Certification of Medical Education of a course of study of at least 960 classroom hours (one academic year) which includes no more than 25 clock hours of basic sciences and 40 clock hours of clinical sciences in a college approved by the Department under the Act within 3 years from the date of application.

5) Successful completion of the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical VariableSpecial Purpose Examination for the United States of America (COMVEX-USACOMSPEX-USA) within 3 years from the date of application. To be successful an applicant must receive a score of 75 or better.

6) For individuals applying for a chiropractic license, proof of completion of 960 classroom hours (academic hours) in an accredited chiropractic program within 3 years from the date of application or the Special Examination for Chiropractic (SPEC) or its equivalent as approved by the Board.

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d) When the accuracy of any submitted documentation, or the relevance or sufficiency of the course work or experience is reasonably questioned by the Department because of discrepancies or conflicts in information, information needing further clarification, and/or missing information, the licensee seeking restoration of a license will be requested to:

1) provide such information as may be necessary; and/or

2) explain such relevance or sufficiency during an oral interview; or

3) appear for an oral interview before the Medical Licensing Board designed to determine the individual's current competency to practice under the Act. Upon the recommendation of the Medical Licensing Board, an applicant shall have his license restored.

e) Placement of a license into an inactive status does not preclude the Department from proceeding with any action pursuant to Section 22 of the Act.

(Source: Amended at 28 Ill. Reg. 5857, effective March 29, 2004)

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1) Heading of the Part: Hospital Licensing Requirements

2) Code Citation: 77 Ill. Adm. Code 250

3) Section Number: 250.435 — Adopted Action: Amendment

4) Statutory Authority: Hospital Licensing Act [210 ILCS 85]

5) Effective date of amendment: March 29, 2004

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain any incorporations by reference? No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the Department's principal office and is available for public inspection.

9) Notices of Proposal was Published in Illinois Register: September 26, 2003; 27 Ill. Reg. 15028

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version: The following changes were made in response to comments received during the First Notice or public comment period:

    1. In Section 250.435(a)(3), "Kidnapping" was stricken and "Kidnaping" was added.

    2. In Section 250.435(m)(1), "Department of" was added and "Illinois" was stricken.

    3. In Section 250.435(n), "*criminal records check*" was added and "*Criminal Records Check*" was stricken.

    4. In Section 250.435(o)(1), "schedule" was added in the first line after "payment".

    5. In Section 250.435(q), quotation marks were added around "disqualifying".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were requested.

13) Will this amendment replace any emergency amendments currently in effect? No

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14) Are there any other amendments pending on this Part? Yes

| Section Numbers | Proposed Action | Ill. Reg. Citation |
|---|---|---|
| 250.2442 | New Section | 27 Ill. Reg. 13345; August 8, 2003 |
| 250.2443 | New Section | 27 Ill. Reg. 13345; August 8, 2003 |

15) Summary and purpose of the amendment: Section 250.435 implements the provisions of the Health Care Worker Background Check Act. The rules are being amended to make changes in the waiver review process, by which an individual convicted of a "disqualifying" crime receives a waiver from the Department that allows the individual to work in a direct care position in a health care facility. Individuals will be required to meet minimum time frames after the conviction date or completion of their sentence before applying for a waiver. Waivers will not be granted to individuals with certain convictions. Requirements that must be met by waiver applicants are being added. The rulemaking also adds examples of "other evidence" demonstrating the ability of the applicant or employee to perform the employment responsibilities competently and evidence that the applicant or employee does not pose a threat to the health or safety of residents. A provision is also being added whereby the Director may grant a waiver to an individual who does not meet these thresholds.

16) Information and questions regarding this adopted amendment shall be directed to:

Susan Meister
Division of Legal Services
Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
217/782-2043
e-mail: rules@idph.state.Il.us

The full text of the adopted amendment begins on the next page:

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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 250
HOSPITAL LICENSING REQUIREMENTS

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250.110 Application for and Issuance of a Permit to Establish a Hospital
250.120 Application for and Issuance of a License to Operate a Hospital
250.130 Administration by the Department
250.140 Hearings
250.150 Definitions
250.160 Incorporated and Referenced Materials

SUBPART B: ADMINISTRATION AND PLANNING

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250.220 Accounting
250.230 Planning
250.240 Admission and Discharge
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250.260 Patients' Rights
250.265 Language Assistance Services
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250.280 Agreement With Designated Organ Procurement Agencies

SUBPART C: THE MEDICAL STAFF

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250.310 Organization
250.315 House Staff Members
250.320 Admission and Supervision of Patients
250.330 Orders for Medications and Treatments
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SUBPART D: PERSONNEL SERVICE

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Section
250.410 Organization
250.420 Personnel Records
250.430 Duty Assignments
250.435 Health Care Worker Background Check
250.440 Education Programs
250.450 Personnel Health Requirements
250.460 Benefits

SUBPART E: LABORATORY

Section
250.510 Laboratory Services
250.520 Blood and Blood Components
250.525 Designated Blood Donor Program
250.530 Proficiency Survey Program (Repealed)
250.540 Laboratory Personnel (Repealed)
250.550 Western Blot Assay Testing Procedures (Repealed)

SUBPART F: RADIOLOGICAL SERVICES

Section
250.610 General Diagnostic Procedures and Treatments
250.620 Radioactive Isotopes
250.630 General Policies and Procedures Manual

SUBPART G: GENERAL HOSPITAL EMERGENCY SERVICE

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250.710 Classification of Emergency Services
250.720 General Requirements
250.725 Notification of Emergency Personnel
250.730 Community or Areawide Planning
250.740 Disaster and Mass Casualty Program
250.750 Emergency Services for Sexual Assault Victims

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Section
250.810 Applicability of Other Parts of These Requirements
250.820 General

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250.830 Classifications of Restorative and Rehabilitation Services
250.840 General Requirements for all Classifications
250.850 Specific Requirements for Comprehensive Physical Rehabilitation Services
250.860 Medical Direction
250.870 Nursing Care
250.880 Additional Allied Health Services

SUBPART I: NURSING SERVICE AND ADMINISTRATION

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250.910 Nursing Services
250.920 Organizational Plan
250.930 Role in hospital planning
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250.950 Nursing committees
250.960 Specialized nursing services
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SUBPART K: ANESTHESIA SERVICES

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SUBPART L: RECORDS AND REPORTS

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SUBPART P: ENGINEERING AND MAINTENANCE OF THE PHYSICAL PLANT, SITE, EQUIPMENT, AND SYSTEMS – HEATING, COOLING, ELECTRICAL, VENTILATION, PLUMBING, WATER, SEWER, AND SOLID WASTE DISPOSAL

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SUBPART U: CONSTRUCTION STANDARDS FOR EXISTING HOSPITALS

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SUBPART W: ALCOHOLISM AND INTOXICATION TREATMENT SERVICES

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250.APPENDIX A Codes and Standards (Repealed)
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250.ILLUSTRATION A Seismic Zone Map
250.TABLE A Measurements Essential for Level I, II, III Hospitals
250.TABLE B Sound Transmission Limitations in General Hospitals
250.TABLE C Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals (Repealed)
250.TABLE D General Pressure Relationships and Ventilation of Certain Hospital Areas (Repealed)
250.TABLE E Piping Locations for Oxygen, Vacuum and Medical Compressed Air
250.TABLE F General Pressure Relationships and Ventilation of Certain Hospital Areas
250.TABLE G Insulation/Building Perimeter

AUTHORITY: Implementing and authorized by the Hospital Licensing Act [210 ILCS 85].

SOURCE: Rules repealed and new rules adopted August 27, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 49, effective May 16, 1978; emergency amendment at 2 Ill. Reg. 31, p. 73, effective July 24, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 45, p. 85, effective November 6, 1978; amended at 3 Ill. Reg. 17, p. 88, effective April 22, 1979; amended at 4 Ill. Reg. 22, p. 233, effective May 20, 1980; amended at 4 Ill. Reg. 25, p. 138, effective June 6, 1980; amended

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at 5 Ill. Reg. 507, effective December 29, 1980; amended at 6 Ill. Reg. 575, effective December 30, 1981; amended at 6 Ill. Reg. 1655, effective January 27, 1982; amended at 6 Ill. Reg. 3296, effective March 15, 1982; amended at 6 Ill. Reg. 7835 and 7838, effective June 17, 1982; amended at 7 Ill. Reg. 962, effective January 6, 1983; amended at 7 Ill. Reg. 5218 and 5221, effective April 4, 1983 and April 5, 1983; amended at 7 Ill. Reg. 6964, effective May 17, 1983; amended at 7 Ill. Reg. 8546, effective July 12, 1983; amended at 7 Ill. Reg. 9610, effective August 2, 1983; codified at 8 Ill. Reg. 19752; amended at 8 Ill. Reg. 24148, effective November 29, 1984; amended at 9 Ill. Reg. 4802, effective April 1, 1985; amended at 10 Ill. Reg. 11931, effective September 1, 1986; amended at 11 Ill. Reg. 10283, effective July 1, 1987; amended at 11 Ill. Reg. 10642, effective July 1, 1987; amended at 12 Ill. Reg. 15080, effective October 1, 1988; amended at 12 Ill. Reg. 16760, effective October 1, 1988; amended at 13 Ill. Reg. 13232, effective September 1, 1989; amended at 14 Ill. Reg. 2342, effective February 15, 1990; amended at 14 Ill. Reg. 13824, effective September 1, 1990; amended at 15 Ill. Reg. 5328, effective May 1, 1991; amended at 15 Ill. Reg. 13811, effective October 1, 1991; amended at 17 Ill. Reg. 1614, effective January 25, 1993; amended at 17 Ill. Reg. 17225, effective October 1, 1993; amended at 18 Ill. Reg. 11945, effective July 22, 1994; amended at 18 Ill. Reg. 15390, effective October 10, 1994; amended at 19 Ill. Reg. 13355, effective September 15, 1995; emergency amendment at 20 Ill. Reg. 474, effective January 1, 1996, for a maximum of 150 days; emergency expired on May 29, 1996; amended at 20 Ill. Reg. 3234, effective February 15, 1996; amended at 20 Ill. Reg. 10009, effective July 15, 1996; amended at 22 Ill. Reg. 3932, effective February 13, 1998; amended at 22 Ill. Reg. 9342, effective May 20, 1998; amended at 23 Ill. Reg. 1007, effective January 15, 1999; emergency amendment at 23 Ill. Reg. 3508, effective March 4, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9513, effective August 1, 1999; amended at 23 Ill. Reg. 13913, effective November 15, 1999; amended at 24 Ill. Reg. 6572, effective April 11, 2000; amended at 24 Ill. Reg. 17196, effective November 1, 2000; amended at 25 Ill. Reg. 3241, effective February 15, 2001; amended at 27 Ill. Reg. 1547, effective January 15, 2003; amended at 27 Ill. Reg. 13467, effective July 25, 2003; amended at 28 Ill. Reg. 5880, effective March 29, 2004.

SUBPART D: PERSONNEL SERVICE

**Section 250.435 Health Care Worker Background Check**

a) The hospital shall not *knowingly hire any individual in a position with duties involving direct care for patients* if that person *has been convicted of committing or attempting to commit one or more of* the following *offenses* (Section 25(a) of the Health Care Worker Background Check Act [225 ILCS 46/25]):

1) Solicitation of murder, solicitation of murder for hire (Sections 8-1.1 and 8-1.2 of the Criminal Code of 1961 [720 ILCS 5/8-1.1 and 8-1.2] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 8-1.1 and 8-1.2));

2) Murder, homicide, manslaughter or concealment of a homicidal death (Sections 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3 of the Criminal Code of 1961 [720 ILCS 5/9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2 and 9-3.3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3; Ill. Rev. Stat. 1985, ch. 38, par. 9-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 3, 236, 358, 360, 361, 362, 363, 364, 364a, 365, 370, 373, 373a, 417 and 474));

3) Kidnaping ~~Kidnapping~~ or child abduction (Sections 10-1, 10-2, 10-5 and 10-7 of the Criminal Code of 1961 [720 ILCS 5/10-1, 10-2, 10-5, and 10-7] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 10-1, 10-2, 10-5, and 10-7; Ill. Rev. Stat. 1985, ch. 38, par. 10-6; Ill. Rev. Stat. 1961, ch. 38, pars. 384 to 386));

4) Unlawful restraint or forcible detention (Sections 10-3, 10-3.1, and 10-4 of the Criminal Code of 1961 [720 ILCS 5/10-3, 10-3.1, and 10-4] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 10-3, 10-3.1, and 10-4; Ill. Rev. Stat. 1961, ch. 38, pars. 252, 252.1, and 252.4));

5) Indecent solicitation of a child, sexual exploitation of a child, exploitation of a child, child pornography (Sections 11-6, 11-9.1, 11-19.2, and 11-20.1 of the Criminal Code of 1961 [720 ILCS 5/11-6, 11-9.1, 11-19.2, and 11-20.1] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 11-6, 11-19.2, and 11-20.1; Ill. Rev. Stat. 1983, ch. 38, par. 11-20a; Ill. Rev. Stat. 1961, ch. 38, pars. 103 and 104));

6) Assault, battery, heinous battery, tampering with food, drugs or cosmetics, or infliction of great bodily harm (Sections 12-1, 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7 of the Criminal Code of 1961 [720 ILCS 5/12-1, 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 12-1, 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7; Ill. Rev. Stat. 1985, ch. 38, par. 9-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 55, 56, and 56a to 60b));

7) Aggravated stalking (Section 12-7.4 of the Criminal Code of 1961 [720 ILCS 5/12-7.4] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-7.4));

8) Home invasion (Section 12-11 of the Criminal Code of 1961 [720 ILCS

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5/12-11] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-11));

9) Criminal sexual~~Sexual~~ assault or criminal sexual abuse (Sections 12-13, 12-14, 12-14.1, 12-15, and 12-16 of the Criminal Code of 1961 [720 ILCS 5/12-13, 12-14, 12-14.1, 12-15, and 12-16] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 11-1, 11-2, 11-3, 11-4, 11-5, 12-13, 12-14, 12-15, and 12-16; Ill. Rev. Stat. 1985, ch. 38, pars. 11-1, 11-4, and 11-4.1; Ill. Rev. Stat. 1961, ch. 38, pars. 109, 141, 142, 490, and 491));

10) Abuse and~~or~~ gross neglect of a long-term care facility resident (Section 12-19 of the Criminal Code of 1961 [720 ILCS 5/12-19] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-19));

11) Criminal abuse or neglect of an elderly or disabled person (Section 12-21 of the Criminal Code of 1961 [720 ILCS 5/12-21] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-21));

12) Endangering the life or health of a child (Section 12-21.6 of the Criminal Code of 1961 [720 ILCS 5/12-21.6] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2354; Ill. Rev. Stat. 1961, ch. 38, par. 95));

13) Ritual mutilation, ritualized abuse of a child (Sections 12-32 and 12-33 of the Criminal Code of 1961 [720 ILCS 5/12-32 and 12-33] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 12-32 and 12-33));

14) Theft, retail theft (Sections 16-1 and 16A-3 of the Criminal Code of 1961 [720 ILCS 5/16-1 and 16A-3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 16-1 and 16A-3; Ill. Rev. Stat. 1961, ch. 38, pars. 62, 207 to 218, 240 to 244, 246, 253, 254.1, 258, 262, 262a, 273, 290, 291, 301a, 354, 387 to 388b, 389, 393 to 400, 404a to 404c, 438, 492 to 496));

15) Financial exploitation of an elderly ~~or disabled~~ person or a person with a disability (Section 16-1.3 of the Criminal Code of 1961 [720 ILCS 5/16-1.3] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 16-1.3));

16) Forgery (Section 17-3 of the Criminal Code of 1961 [720 ILCS 5/17-3] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 17-3; Ill. Rev. Stat. 1961, ch. 38, pars. 151 and 277 to 286));

17) Robbery, armed robbery (Sections 18-1 and 18-2 of the Criminal Code of 1961 [720 ILCS 5/18-1 and 18-2] (formerly Ill. Rev. Stat. 1991, ch. 38,

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pars. 18-1 and 18-2));

18) Vehicular hijacking, aggravated vehicular hijacking, aggravated robbery (Sections 18-3, 18-4, and 18-5 of the Criminal Code of 1961 [720 ILCS 5/18-3, 18-4, and 18-5]);

19) Burglary, residential burglary (Sections 19-1 and 19-3 of the Criminal Code of 1961 [720 ILCS 5/19-1 and 19-3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 19-1 and 19-3; Ill. Rev. Stat. 1961, ch. 38, pars. 84 to 86, 88 and 501));

20) Criminal trespass to a residence (Section 19-4 of the Criminal Code of 1961 [720 ILCS 5/19-4] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 19-4));

21) Arson (Sections 20-1 and 20-1.1 of the Criminal Code of 1961 [720 ILCS 5/20-1 and 20-1.1] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 20-1 and 20-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 48 to 53 and 236 to 238));

22) Unlawful use of weapons, aggravated discharge of a firearm, or reckless discharge of a firearm (Sections 24-1, 24-1.2, and 24-1.5 of the Criminal Code of 1961 [720 ILCS 5/24-1, 24-1.2, and 24-1.5] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 24-1 and 24-1.2; Ill. Rev. Stat. 1961, ch. 38, pars. 152, 152a, 155, 155a to 158b, 414a to 414c, 414e and 414g));

23) Armed violence - elements of the offense (Section 33A-2 of the Criminal Code of 1961 [720 ILCS 5/33A-2] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 33A-2));

24) Those provided in Section 4 of the Wrongs to Children Act (Section 4 of the Wrongs to Children Act [720 ILCS 150/4] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2354));

25) Cruelty to children (Section 53 of the Criminal Jurisprudence Act [720 ILCS 115/53] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2368));

26) Manufacture, delivery or trafficking of cannabis, delivery of cannabis on school grounds, ~~or~~ delivery to person under 18,~~;~~ violation by person under 18 (Sections 5, 5.1, 5.2, 7, and 9 of the Cannabis Control Act [720 ILCS 550/5, 5.1, 5.2, 7, and 9] (formerly Ill. Rev. Stat. 1991, ch. 56½, pars. 705, 705.1, 705.2, 707, and 709)); or

27) Manufacture, delivery or trafficking of controlled substances (Sections 401, 401.1, 404, 405, 405.1, 407, and 407.1 of the Illinois Controlled Substance Act [720 ILCS 570/401, 401.1, 404, 405, 405.1, 407, and 407.1] (formerly Ill. Rev. Stat. 1991, ch. 56½, pars. 1401, 1401.1, 1404, 1405, 1405.1, 1407, and 1407.1)).

b) The hospital shall not *knowingly employ or retain any individual in a position with duties involving direct care for patients* if that person *has been convicted of committing or attempting to commit one or more of the offenses* listed in subsections (a)(1) to (27) of this Section *unless the applicant, employee,* or employer *obtains a waiver pursuant to* ~~subsections (m) and (o) of~~ this Section. (Section 25(a) of the Health Care Worker Background Check Act)

c) *A* hospital *shall not hire, employ, or retain any individual in a position with duties involving direct care of patients if the hospital becomes aware that the individual has been convicted in another state of committing or attempting to commit an offense that has the same or similar elements as an offense listed in* subsections (a)(1) to (27) of this Section *as verified by court records, records from a State agency, or an FBI criminal history record check. This shall not be construed to mean that a hospital has an obligation to conduct a criminal history records check in other states in which an employee has resided.* (Section 25(b) of the Act)

d) For the purpose of this Section:

1) "*Applicant*" *means an individual seeking employment with a* hospital *who has received a bona fide conditional offer of employment.*

2) *"Conditional offer of employment" means a bona fide offer of employment by a* hospital *to an applicant, which is contingent upon the receipt of a report from the Department of State Police indicating that the applicant does not have a record of conviction of any of the criminal offenses* listed in subsections (a)(1) to (27) of this Section.

3) *"Direct Care" means the provision of nursing care or assistance with feeding, dressing, movement, bathing, or other personal needs.*

4) *"Initiate" means the obtaining of the authorization for a record check from a student, applicant, or employee.* (Section 15 of the Health Care Worker Background Check Act)

e) For purposes of the Health Care Worker Background Check Act, the hospital

shall establish a policy defining which employees provide direct care. In making this determination the hospital shall consider the following:

1) The employee's assigned job responsibilities as set forth in the employee's job description;

2) Whether the employee is required to or has the opportunity to be alone with patients, with the exception of infrequent or unusual occasions; and

3) Whether the employee's responsibilities include physical contact with patients, for example to provide therapy or to draw blood.

f) *Beginning January 1, 1996*, when the hospital *makes a conditional offer of employment to an applicant* who is not exempt under subsection (ws) of this Section, *for a position with duties that involve direct care for patients,* the employer *must initiate or have initiated on* its *behalf a* Uniform Conviction Information Act (UCIA) *criminal history record check for that applicant.* (Section 30(c) of the Health Care Worker Background Check Act) If the applicant is on the Department's Nurse Aide Registry in good standing and has had a UCIA criminal history record check within the last 12 months, the employer need not initiate another check.

g) *The* hospital *shall transmit all necessary information and fees to the Illinois State Police within 10 working days after receipt of the authorization.* (Section 15 of the Health Care Worker Background Check Act)

h) The hospital may accept an authentic UCIA criminal history record check that has been conducted within the last 12 months rather than initiating a check as required in subsection (f) of this Section.

i) *The request for a UCIA criminal history record check shall be* made as *prescribed by the Department of State Police. The applicant or employee must be notified of the following whenever a non-fingerprint*-based *UCIA* criminal history record *check is made:*

1) *That the* hospital *shall request or have requested on its behalf a* non-fingerprint-based *UCIA criminal history record check pursuant to* the Health Care Worker Background Check *Act.*

2) *That the applicant or employee has a right to obtain a copy of the criminal records report from the* hospital*, challenge the accuracy and completeness*

*of the report, and request a waiver* in accordance with ~~subsection (m) of~~ this Section.

3) *That the applicant, if hired conditionally, may be terminated if the* non-fingerprint-based *criminal records report indicates that the applicant has a record of conviction of any of the criminal offenses enumerated in* subsections (a)(1) to (27) of this Section *unless the applicant's identity is validated and it is determined that the applicant* or employee *does not have a disqualifying criminal history record based on a fingerprint-based records check pursuant to* subsection (k) of this Section.

4) *That the applicant, if not hired conditionally, shall not be hired if the* non-fingerprint-based *criminal records report indicates that the applicant has a record of conviction of any of the criminal offenses enumerated in* subsections (a)(1) to (27) of this Section *unless the applicant's record is cleared based on a fingerprint-based records check pursuant to* subsection (k) of this Section.

5) *That the employee may be terminated if the criminal records report indicates that the employee has a record of conviction of any of the criminal offenses enumerated in* subsections (a)(1) to (27) of this Section *unless the employee's* record is cleared based on a fingerprint-based records check pursuant to subsection (k) of this Section. (Section 30(e) and (f) of the Health Care Worker Background Check Act)

j) A hospital *may conditionally employ an applicant to provide direct care for up to three months pending the results of a UCIA criminal history record check.* (Section 30(g) of the Health Care Worker Background Check Act)

k) *An applicant or employee whose* non-fingerprint-based *UCIA criminal history record check indicates a conviction for committing or attempting to commit one or more of the offenses* listed in subsections (a)(1) to (27) of this Section *may request that the* hospital *or its designee commence a fingerprint-based UCIA criminal records check by submitting any necessary fees and information in a form and manner prescribed by the Department of State Police.* (Section 35 of the Health Care Worker Background Check Act)

l) *A* hospital *having actual knowledge from a source other than a non-fingerprint check that an employee has been convicted of committing or attempting to commit one of the offenses enumerated in Section 25 of* the *Act must initiate a fingerprint-based background check within 10 working days after acquiring that knowledge.*

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*The* hospital *may continue to employ that individual in a direct care position, may reassign that individual to a non-direct care position, or may suspend the individual until the results of the fingerprint-based background check are received.* (Section 30(d) of the Health Care Worker Background Check Act)

m) *An applicant, employee* or employer *may request a waiver* to subsection (a), (b), or (c) of this Section *by submitting the following* to the Department *within five working days after the receipt of the criminal records report:*

1) A completed *fingerprint-based UCIA criminal records check* form (Section 40(a) of the Health Care Worker Background Check Act) (which the Department will forward to the Department of ~~Illinois~~ State Police); and

2) A certified check, money order or hospital check made payable to the Department of State Police for the amount of money necessary to initiate a fingerprint-based UCIA criminal records check.

n) *The Department may accept the results of the fingerprint-based UCIA criminal records check ~~Criminal Records Check~~ instead of the items required by* subsections (m)(1) and (2) above. (Section 40(a-5) of the Health Care Worker Background Check Act)

o) An application for a waiver shall be denied unless the applicant meets the following requirements and submits documentation thereof with the waiver application:

1) Except in the instance of payment of court-imposed fines or restitution in which the applicant is adhering to a payment schedule, the applicant shall have met all obligations to the court and under terms of parole (i.e., probation has been successfully completed); and

2) The applicant shall have satisfactorily completed a drug and/or alcohol recovery program, if drugs and/or alcohol were involved in the offense.

p)~~o)~~ The Department *may grant a waiver based on mitigating circumstances, which may include:*

1) *The age of the individual at which the crime was committed;*

2) *The circumstances surrounding the crime;*

3) *The length of time since the conviction;*

4) *The applicant's or employee's criminal history since the conviction;*

5) *The applicant's or employee's work history;*

6) *The applicant's or employee's current employment references;*

7) *The applicant's or employee's character references;*

8) *Nurse Aide Registry records; and*

9) *Other evidence demonstrating the ability of the applicant or employee to perform the employment responsibilities competently and evidence that the applicant or employee does not pose a threat to the health or safety of patients*, which may include, but is not limited to the applicant's or employee's participation in a drug/alcohol rehabilitation program and continued involvement in recovery; the applicant's or employee's participation in anger management or domestic violence prevention programs; the applicant's or employee's status on nurse aide registries in other states; the applicant's or employee's criminal history in other states; or the applicant's or employee's successful completion of all outstanding obligations or responsibilities imposed by or to the court.. (Section 40(b) of the Health Care Worker Background Check Act)

q) Waivers will not be granted to individuals who have not met the following time frames. "Disqualifying" refers to offenses listed in subsections (a)(1) to (27) of this Section:

1) Single disqualifying misdemeanor conviction − waiver consideration no earlier than one year after the conviction date;

2) Two to three disqualifying misdemeanor convictions − waiver consideration no earlier than three years after the most recent conviction date;

3) More than three disqualifying misdemeanor convictions − waiver consideration no earlier than five years after the most recent conviction date;

4) Single disqualifying felony convictions – waiver consideration no earlier than three years after the conviction date;

5) Two to three disqualifying felony convictions – waiver consideration no earlier than five years after the most recent conviction date;

6) More than three disqualifying felony convictions – waiver consideration no earlier than ten years after the most recent conviction date.

r) Waivers will not be granted to individuals who have been convicted of committing or attempting to commit one or more of the following offenses:

1) Solicitation of murder, solicitation of murder for hire (Sections 8-1.1 and 8-1.2 of the Criminal Code of 1961 [720 ILCS 5/8-1.1 and 8-1.2]);

2) Murder, homicide, manslaughter, or concealment of a homicidal death (Sections 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3 of the Criminal Code of 1961 [720 ILCS 5/9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3]);

3) Kidnaping or aggravated kidnaping (Sections 10-1 and 10-2 of the Criminal Code of 1961 [720 ILCS 5/10-1 and 10-2]);

4) Aggravated battery, heinous battery, or infliction of great bodily harm (Sections 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.6, and 12-4.7 of the Criminal Code 1961 [720 ILCS 5/12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.6, and 12-4.7]);

5) Criminal sexual assault or aggravated criminal sexual assault (Sections 12-13, 12-14, and 12-14.1 of the Criminal Code of 1961 [720 ILCS 5/12-13, 12-14, and 12-14.1]);

6) Criminal sexual abuse or aggravated criminal sexual abuse (Sections 12-15 and 12-16 of the Criminal Code of 1961 [720 ILCS 5/12-15 and 12-16]);

7) Abuse and gross neglect of a long-term care facility resident (Section 12-19 of the Criminal Code of 1961 [720 ILCS 5/12-19]);

8) Criminal abuse or neglect of an elderly or disabled person (Section 12-21 of the Criminal Code of 1961 [720 ILCS 5/12-21]);

9) Financial exploitation of an elderly person or a person with a disability (Section 16-1.3 of the Criminal Code of 1961 [720 ILCS 5/16-1.3]);

10) Indecent solicitation of a child, sexual exploitation of a child, exploitation of a child, child pornography (Sections 11-6, 11-9.1, 11-19.2, and 11-20.1 of the Criminal Code of 1961 [720 ILCS 5/11-6, 11-9.1, 11-19.2, and 11-20.1]);

11) Armed robbery (Section 18-2 of the Criminal Code of 1961 [720 ILCS 5/18-2]); and

12) Aggravated vehicular hijacking, aggravated robbery (Sections 18-4 and 18-5 of the Criminal Code of 1961 [720 ILCS 5/18-4 and 18-5]).

s) The Director of Public Health may grant a waiver to an individual who does not meet the requirements of subsection (o), (q), or (r), *based on mitigating circumstances* (see subsection (p)). (Section 40(b) of the Health Care Worker Background Check Act)

t)~~p)~~ *An individual shall not be employed in a direct care position from the time that the employer receives the results of a non-fingerprint check containing disqualifying conditions until the time that the individual receives a waiver from the Department. If the individual challenges the results of the non-fingerprint check, the employer may continue to employ the individual in a direct care position if the individual presents convincing evidence to the employer that the non-fingerprint check is invalid. If the individual challenges the results of the non-fingerprint check, his or her identity shall be validated by a fingerprint-based records check in accordance with* subsection (k) of this Section. (Section 40(d) of the Health Care Worker Background Check Act)

u)~~q)~~ A hospital *is not obligated to employ or offer permanent employment to an applicant, or to retain an employee who is granted a waiver.* (Section 40(f) of the Health Care Worker Background Check Act)

v)~~r)~~ A hospital may retain the individual in a direct care position if the individual presents clear and convincing evidence to the hospital that the non-fingerprint-based criminal records report is invalid and if there is a good faith belief on the part of the employer that the individual did not commit an offense listed in subsections (a)(1) to (27) of this Section, pending positive verification through a fingerprint-based criminal records check. Such evidence may include, but not be

limited to:

1) certified court records;

2) written verification from the State's Attorney's office that prosecuted the conviction at issue;

3) written verification of employment during the time period during which the crime was committed or during the incarceration period stated in the report;

4) a signed affidavit from the individual concerning the validity of the report; or

5) documentation from a local law enforcement agency that the individual was not convicted of a disqualifying crime.

w)~~s)~~ This Section *shall not apply to:*

1) *an individual who is licensed by the Department of Professional Regulation or the Department of Public Health under another law of this State*; or

2) *an individual employed or retained by a health care employer for whom a criminal background check is required by another law of this State; or*

3) *a student in a licensed health care field including, but not limited to, a student nurse, a physical therapy student, or a respiratory care student unless he or she is employed by a health care employer in a position with duties involving direct care for* patients. (Section 20 of the Health Care Worker Background Check Act)

x)~~t)~~ *An employer need not initiate an additional criminal background check for an employee if the employer initiated a criminal background check for the employee after January 1, 1996 and prior to* January 1, 1998. *This subsection applies only to persons employed prior to* January 1, 1998. *Any person newly employed on or after* January 1, 1998 *must receive a background check as required by Section 30* of the Health Care Worker Background Check Act. (Section 25.1 of the Health Care Worker Background Check Act)

y)~~u)~~ *The* hospital *shall send a copy of the results of the UCIA* criminal history *record check to the State Nurse Aide Registry* for those individuals who are on the

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Registry. (Section 30(b) of the Health Care Worker Background Check Act) The hospital shall include the individual's Social Security number on the criminal history record check results.

z)~~v)~~ *The* hospital *shall retain on file for a period of 5 years records of criminal records requests for all employees*. *The* hospital *shall retain the results of the UCIA criminal history records check and waiver, if appropriate, for the duration of the individual's employment. The files shall be subject to inspection by the* Department. A *fine of $500* shall *be imposed for failure to maintain these records.* (Section 50 of the Health Care Worker Background Check Act)

aa)~~w)~~ The hospital shall maintain a copy of the employee's criminal history record check results and waiver, if applicable, in the personnel file or other secure location accessible to the Department.

(Source: Amended at 28 Ill. Reg. 5880, effective March 29, 2004)

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1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Emergency Action:
148.295 Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-0092

5) Effective Date: April 1, 2004

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: No

7) Date Filed with the Index Department: March 29, 2004

8) A copy of the emergency amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Reason for Emergency: These emergency amendments are being filed pursuant to the enactment of the State's budget implementation plan for fiscal year 2004. The amendments provide certain funding increases for high volume Medicaid funded hospitals under Critical Hospital Adjustment Payments (CHAP) for Direct Hospital Adjustment (DHA) payments. Immediate implementation of these amendments is necessary to ensure access to essential medical services for public assistance clients. Emergency rulemaking is specifically authorized for the implementation of these changes for fiscal year 2004 by Section 5-45 of Public Act 93-0020.

10) Complete Description of the Subjects and Issues Involved: These emergency amendments concerning hospital services provide additional fiscal year 2004 budget implementation changes. Funding increases will be provided for high volume Medicaid funded hospitals under Critical Hospital Adjustment Payments (CHAP) for Direct Hospital Adjustment (DHA) payments. The proposed changes are the result of a line item veto override in veto session that restored certain hospital funding. The changes are expected to result in a spending increase of approximately $1.7 million.

11) Are there any other amendments pending on this Part? Yes

Section Numbers: Proposed Action Illinois Register Citation

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| | | |
|---|---|---|
| 148.30 | Amendment | February 6, 2004 (28 Ill. Reg. 1998) |
| 148.82 | Amendment | January 23, 2004 (28 Ill. Reg. 1350) |
| 148.85 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.90 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.95 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.100 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.103 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.110 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.112 | New Section | April 9, 2004 (28 Ill. Reg.5808) |
| 148.150 | Amendment | March 19, 2004 (28 Ill. Reg. 4848) |
| 148.210 | Amendment | February 6, 2004 (28 Ill. Reg. 1998) |
| 148.295 | Amendment | February 27, 2004 (28 Ill. Reg. 3719) |
| 148.310 | Amendment | April 9, 2004 (28 Ill. Reg.5808) |

12) Statement of Statewide Policy Objectives: These emergency amendments neither create nor expand any State mandates affecting units of local government.

13) Information and questions regarding this amendment shall be directed to:

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Public Aid
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002
(217) 524-0081

The full text of the Emergency Amendment begins on the next page:

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NOTICE OF EMERGENCY AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

Section
148.10 Hospital Services
148.20 Participation
148.25 Definitions and Applicability
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Services Not Covered as Hospital Services
148.70 Limitation On Hospital Services

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.90 Heart Transplants (Repealed)
148.100 Liver Transplants (Repealed)
148.105 Psychiatric Adjustment Payments
148.110 Bone Marrow Transplants (Repealed)
148.115 Rural Adjustment Payments
148.120 Disproportionate Share Hospital (DSH) Adjustments
148.122 Medicaid Percentage Adjustments
148.126 Safety Net Adjustment Payments
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Public Law 103-66 Requirements
148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million
148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals

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Organized Under the Town Hospital Act
148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 Alternate Reimbursement Systems
148.210 Filing Cost Reports
148.220 Pre September 1, 1991, Admissions
148.230 Admissions Occurring on or after September 1, 1991
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 Calculation and Definitions of Inpatient Per Diem Rates
148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.285 Excellence in Academic Medicine Payments
148.290 Adjustments and Reductions to Total Payments
148.295 Critical Hospital Adjustment Payments (CHAP)
EMERGENCY
148.296 Tertiary Care Adjustment Payments
148.297 Pediatric Outpatient Adjustment Payments
148.298 Pediatric Inpatient Adjustment Payments
148.300 Payment
148.310 Review Procedure
148.320 Alternatives
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services
148.350 Definitions (Repealed)
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.368 Volume Adjustment (Repealed)
148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.390 Hearings
148.400 Special Hospital Reporting Requirements

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

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Section
148.500 Definitions
148.510 Reimbursement

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section
148.600 Definitions
148.610 Scope of the Program
148.620 Assistance Level and Reimbursement
148.630 Criteria and Information Required to Establish Eligibility
148.640 Covered Services

148.TABLE A Renal Participation Fee Worksheet
148.TABLE B Bureau of Labor Statistics Equivalence
148.TABLE C List of Metropolitan Counties by SMSA Definition

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a

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maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002;

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amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

**Section 148.295 Critical Hospital Adjustment Payments (CHAP)**
**EMERGENCY**

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section.

a) Trauma Center Adjustments (TCA)

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The Department shall make a TCA to Illinois hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH) in accordance with the provisions of subsections (a)(1) through (a)(3) of this Section.

1) Level I Trauma Center Adjustment.

A) Criteria. Illinois hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by the Illinois Department of Public Health shall receive the Level I trauma center adjustment.

B) Adjustment. Illinois hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:

i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $21,365.00 per Medicaid trauma admission in the CHAP base period.

ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $14,165.00 per Medicaid trauma admission in the CHAP base period.

2) Level II Rural Trauma Center Adjustment. Illinois rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period.

3) Level II Urban Trauma Center Adjustment. Illinois urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:

A) The hospital is located in a county with no Level I trauma center; and

B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(3) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(3) of this Section.

b) Rehabilitation Hospital Adjustment (RHA)
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive $4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.

2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360.00 in the CHAP rate period.

B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $527,528.00 in the CHAP rate period.

3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on

July 1, 1999, shall receive $276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

c) Direct Hospital Adjustment (DHA) Criteria

1) Qualifying Criteria
Hospitals may qualify for the DHA under this subsection (c) under the following categories:

A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999, and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999, and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999, and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(c)(3), on July 1, 1999.

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D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.

E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999, and provided more than 15,000 Total days.

F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999, and provided more than 7,500 Total days and provided obstetrical care as of July 1, 2001.

G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999, that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999, and provided 75 or more Alzheimer days for patients diagnosed as having the disease.

H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.

2) DHA Rates

A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:

i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.

ii) Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive $105.00 per day for hospitals that do not provide obstetrical care and $142.00 per day for hospitals that do provide obstetrical care.

iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.

iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.

B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:

i) County owned hospitals as defined in Section 148.25 with more than 30,000 Total days will have their rate increased by $455.00 per day.

ii) Hospitals that are not county owned with more than 30,000 Total days will have their rate increased by $330.00 per day.

iii) Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.

iv) Hospitals with more than 4,500 Obstetrical days will have their rate increased by $101.00 per day.

v) Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional $194.00 per day.

vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by $147.00 per day.

vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by $41.00 per day.

viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by $227.00 per day.

ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by $182.25 per day.

x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by $202.00 per day.

xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by $98.00 per day.

C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:

i) Qualifying hospitals will receive a rate of $421.00 per day.

ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by $369.00 per day.

D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:

i) Hospitals will receive a rate of $28.00 per day.

ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by $55.00 per day.

iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by $573.00 per day.

iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have fewer than 4,000 Total days; or $246.00 per day for hospitals that have more than 4,000 Total days but fewer than 8,000 Total days; or $178.00 per day for hospitals that have more than 8,000 Total days.

v) Hospitals with more than 3,200 Total admissions will have their rate increased by $248.00 per day.

E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:

i) Hospitals will receive a rate of $41.00 per day.

ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.

iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.

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iv) Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional $41.00 per day.

F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive $188.00 per day.

G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of $55.00 per day.

H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:

i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of $69.00~~$34.50~~ per day.

ii) Hospitals with an MIUR equal to or less than 19.75 percent will receive a rate of $11.00~~$5.50~~ per day.

I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day.

J) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.

3) DHA Payments

A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.

B) Payment rates will be multiplied by the Total days.

C) Total Payment Adjustments

i) For the CHAP rate period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period April 1, 2004~~October 1, 2003~~, to June 30, 2004, payment will equal the State fiscal year 2004 amount less the amount the hospital received under DHA for the quarters ending~~quarter ended~~ September 30, 2003, December 31, 2003, and March 31, 2004.

ii) For CHAP rate periods occurring after State fiscal year 2004, total payments will equal the methodologies described in subsection (c)(2) of this Section.

d) Rural Critical Hospital Adjustment Payments (RCHAP)
RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:

1) the product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

2) the product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

e) Total CHAP Adjustments
Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.

f) Critical Hospital Adjustment Limitations
Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section.

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In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

g) Critical Hospital Adjustment Payment Definitions
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.

2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995, CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996, CHAP rate period; etc.

3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.

4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.

5) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

6) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80,

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853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.

8) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

9) "Medicaid trauma admission" means those claims billed as admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

10) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.

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11) "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.

12) "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.

13) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

14) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

15) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Amended by emergency rulemaking at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PUBLIC HEARINGS ON PROPOSED AMENDMENTS

1) Heading of the Part: Medicaid Community Mental Health Services Program

2) Code Citation: 59 Ill. Adm. Code 132

3) Register Citation to Notice of Proposed Rules: 28 Ill. Reg. 3954, March 5, 2004

4) Date, Time and Location of Public Hearings:

Thursday, April 15, 2004
10:00 a.m. – 12:00 p.m.
Singer Mental Health Center
4402 North Main Street
Auditorium
Rockford, Illinois 61103

Friday, April 16, 2004
10:00 a.m. – 12:00 p.m.
Michael A. Bilandic Building
160 North LaSalle, 5th Floor
Room C-500
Chicago, Illinois 60601

Wednesday, April 21, 2004
10:00 a.m. – 12:00 p.m.
Alton Mental Health Center
4500 College Avenue
Auditorium Building
Alton, Illinois 62002

Thursday, April 22, 2004
10:00 a.m. – 12:00 p.m.
Choate Mental Health Center
1000 North Main Street
Training Center Auditorium, Main Building
Anna, Illinois 62906

Friday, April 23, 2004
10:00 a.m. – 12:00 p.m.
Illinois Central College North
5407 N. University Street
Room A261
Peoria, Illinois 61614

Monday, April 26, 2004
10:00 a.m. – 12:00 p.m.
Lincoln Library
Carnegie Room
326 South 7th Street
Springfield, Illinois 62701

5) Other Pertinent Information: The hearing will be held for the sole purpose of gathering public comments on the proposed amendments. Persons interested in presenting testimony at this hearing are advised that the Illinois Department of Human Services will adhere to the following procedures in the conduct of the hearing:

A) No oral testimony shall exceed an aggregate of ten (10) minutes.

B) Each person presenting oral testimony shall provide to the hearing officer a written (preferably typed) copy of such testimony at the time the oral testimony is presented. No oral testimony will be accepted without a written copy of the testimony being provided.

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NOTICE OF PUBLIC HEARINGS ON PROPOSED AMENDMENTS

C) No person will be recognized to speak for a second time until all persons wishing to testify have done so.

D) In order to provide for a balanced presentation of views and to facilitate the orderly conduct of the hearing, the hearing officer may impose such other rules of procedures, including the order of call of witnesses, as she/he deems necessary.

E) Persons requiring reasonable accommodation due to disability must contact the Bureau of Administrative Rules and Procedures by April 13, 2004.

6) Name and Address of Agency Contact Person: Questions regarding these proposed amendments or the public hearings shall be directed to:

Tracie Drew, Bureau Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue, East, 3rd Floor, Harris Bldg.
Springfield, Illinois 62762
Telephone number: (217) 785-9772

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO PROPOSED RULEMAKING

ILLINOIS BUILDING COMMISSION

Heading of the Part: Alternative Dispute Resolution Procedure

Code Citation: 2 Ill. Adm. Code 3203

| Section Numbers: | 3203.101 | 3203.102 | 3203.105 | |
|---|---|---|---|---|
| | | 3203.115 | 3203.120 | 3203.125 |
| | | 3203.130 | 3203.135 | 3203.140 |
| | | 3203.145 | 3203.150 | |
| | | 3203.APPENDIX A | 3203.APPENDIX B | |
| | | 3203.APPENDIX C | 3203.APPENDIX D | |
| | | 3203.APPENDIX E | | |

Date Originally Published in the Illinois Register: 11/21/03
27 Ill. Reg. 17322

At its meeting on February 18, 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommended that, as the Illinois Building Commission (IBC) does not have specific statutory authority to charge the fees set out in its rulemaking titled Alternative Dispute Resolution Procedure (2 Ill. Adm. Code 3203; 27 Ill. Reg. 17322), IBC withdraw this rulemaking and secure statutory authority for charging these fees.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO PROPOSED RULEMAKING

ILLINOIS RACING BOARD

Heading of the Part: Race Track Operators and Their Duties

Code Citation: 11 Ill. Adm. Code 1305

Section Numbers: 1305.380

Date Originally Published in the Illinois Register: 4/18/03
27 Ill. Reg. 7218

At its meeting on March 23 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommends that IRB be more timely in updating its rules to reflect statutory changes.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO PROPOSED RULEMAKING

ILLINOIS RACING BOARD

Heading of the Part: License and Applications; Association Licenses

Code Citation: 11 Ill. Adm. Code 1407

Section Numbers: 1407.52

Date Originally Published in the Illinois Register: 4/18/03
27 Ill. Reg. 7222

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommends that IRB be more timely in updating its rules to reflect statutory changes.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO PROPOSED RULEMAKING

ILLINOIS RACING BOARD

Heading of the Part: Regulations for Meetings

Code Citation: 11 Ill. Adm. Code 1424

Section Numbers: 1424.360

Date Originally Published in the Illinois Register: 4/18/03
27 Ill. Reg. 7226

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommends that IRB be more timely in updating its rules to reflect statutory changes.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO EMERGENCY RULEMAKING

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Heading of the Part: Senior Citizens and Disabled Persons Prescription Drug Discount Program

Code Citation: 80 Ill. Adm. Code 2151

| Section Numbers: | 2151.10 | 2151.20 | 2151.30 |
|---|---|---|---|
| | 2151.40 | 2151.50 | 2151.60 |
| | 2151.70 | 2151.80 | 2151.90 |
| | 2151.100 | 2151.110 | 2151.120 |

Date Originally Published in the Illinois Register: 3/5/04
28 Ill. Reg. 4379

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommends that the Department of Central Management Services adopt rules implementing Public Acts in a more timely manner, especially when statute specifies an implementation date. Public Act 93-18 (effective 7/1/03) included a 1/1/04 deadline for program startup. It is also recommended that, when CMS adopts permanent rules implementing this program, it add substantive provisions called for by Sections 25, 35, 40 and 45 of the Act.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF RECOMMENDATION
TO PROPOSED RULEMAKING

DEPARTMENT OF HUMAN SERVICES

Heading of the Part: Child Care

Code Citation: 89 Ill. Adm. Code 50

| Section Numbers: | 50.210 | 50.230 | |
|---|---|---|---|
| | | 50.235 | 50.240 |
| | | 50.310 | 50.320 |

Date Originally Published in the Illinois Register: 8/22/03
27 Ill. Reg. 13919

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules considered the above cited rulemaking and recommended that within 6 months DHS propose amendments to the Child Care rules (89 Ill. Adm. Code 50) to specify all of the standards that must be met and the relevant documentation required to verify legitimate employment or self-employment for child care assistance purposes without regard to where the work is performed.

The agency should respond to this Recommendation in writing within 90 days after receipt of this Statement. Failure to respond will constitute refusal to accede to the Committee's Recommendation. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF OBJECTION
TO PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC HEALTH

Heading of the Part: Skilled Nursing and Intermediate Care Facilities Code

Code Citation: 77 Ill. Adm. Code 300

Section Numbers: 300.120

Date Originally Published in the Illinois Register: 8/29/03
27 Ill. Reg. 14162

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules objected to the above cited rulemaking because the fee for facilities with more than 100 beds adds an extra $10 fee per bed, rather than just an extra $10 per bed over 100 total beds. The Committee believes this rulemaking contravenes the intent of the General Assembly that the fee for facilities with more than 100 beds is $1000 plus $10 per bed for all beds over 100.

Failure of the agency to respond within 90 days after receipt of the Statement of Objection shall constitute withdrawal of this proposed rulemaking. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF OBJECTION
TO PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC HEALTH

Heading of the Part: Sheltered Care Facilities Code

Code Citation: 77 Ill. Adm. Code 330

Section Numbers: 330.120

Date Originally Published in the Illinois Register: 8/29/03
27 Ill. Reg. 14164

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules objected to the above cited rulemaking because the fee for facilities with more than 100 beds adds an extra $10 fee per bed, rather than just an extra $10 per bed over 100 total beds. The Committee believes this rulemaking contravenes the intent of the General Assembly that the fee for facilities with more than 100 beds is $1000 plus $10 per bed for all beds over 100.

Failure of the agency to respond within 90 days after receipt of the Statement of Objection shall constitute withdrawal of this proposed rulemaking. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF OBJECTION
TO PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC HEALTH

Heading of the Part: Illinois Veterans' Homes Code

Code Citation: 77 Ill. Adm. Code 340

Section Numbers: 340.1120

Date Originally Published in the Illinois Register: 8/29/03
27 Ill. Reg. 14166

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules objected to the above cited rulemaking because the fee for facilities with more than 100 beds adds an extra $10 fee per bed, rather than just an extra $10 per bed over 100 total beds. The Committee believes this rulemaking contravenes the intent of the General Assembly that the fee for facilities with more than 100 beds is $1000 plus $10 per bed for all beds over 100.

Failure of the agency to respond within 90 days after receipt of the Statement of Objection shall constitute withdrawal of this proposed rulemaking. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF OBJECTION
TO PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC HEALTH

Heading of the Part: Intermediate Care for the Developmentally Disabled Facilities Code

Code Citation: 77 Ill. Adm. Code 350

Section Numbers: 350.1230

Date Originally Published in the Illinois Register: 8/29/03
27 Ill. Reg. 14168

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules objected to the above cited rulemaking because the fee for facilities with more than 100 beds adds an extra $10 fee per bed, rather than just an extra $10 per bed over 100 total beds. The Committee believes this rulemaking contravenes the intent of the General Assembly that the fee for facilities with more than 100 beds is $1000 plus $10 per bed for all beds over 100.

Failure of the agency to respond within 90 days after receipt of the Statement of Objection shall constitute withdrawal of this proposed rulemaking. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

STATEMENT OF OBJECTION
TO PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC HEALTH

Heading of the Part: Long-Term Care for Under Age 22 Facilities Code

Code Citation: 77 Ill. Adm. Code 390

Section Numbers: 390.120

Date Originally Published in the Illinois Register: 8/29/03
27 Ill. Reg. 14170

At its meeting on March 23, 2004, the Joint Committee on Administrative Rules objected to the above cited rulemaking because the fee for facilities with more than 100 beds adds an extra $10 fee per bed, rather than just an extra $10 per bed over 100 total beds. The Committee believes this rulemaking contravenes the intent of the General Assembly that the fee for facilities with more than 100 beds is $1000 plus $10 per bed for all beds over 100.

Failure of the agency to respond within 90 days after receipt of the Statement of Objection shall constitute withdrawal of this proposed rulemaking. The agency's response will be placed on the JCAR agenda for further consideration.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of March 23, 2004 through March 29, 2004 and have been scheduled for review by the Committee at its April 20, 2004 meeting in Springfield. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

| Second Notice Expires | Agency and Rule | Start Of First Notice | JCAR Meeting |
|---|---|---|---|
| 5/6/04 | Department of Insurance, Premium Fund Trust Account (50 Ill. Adm. Code 3113) | 12/26/03 27 Ill. Reg. 19108 | 4/20/04 |
| 5/7/04 | Office of Banks and Real Estate, Illinois Savings and Loan Act of 1985 (38 Ill. Adm. Code 1000) | 2/6/04 28 Ill. Reg. 1820 | 4/20/04 |
| 5/7/04 | Office of Banks and Real Estate, Savings Bank Act (38 Ill. Adm. Code 1075) | 2/6/04 28 Ill. Reg. 1835 | 4/20/04 |
| 5/9/04 | Department of Natural Resources, Dog Training on Non-Department Owned or –Managed Lands (17 Ill. Adm. Code 960) | 2/6/04 28 Ill. Reg. 1993 | 4/20/04 |
| 5/9/04 | Department of Natural Resources, Non-Departmental Archaeological Research on Department of Natural Resources Managed Lands (17 Ill. Adm. Code 390) | 2/6/04 28 Ill. Reg. 1935 | 4/20/04 |
| 5/9/04 | Department of Natural Resources, The Protection of Archaeological Resources (17 Ill. Adm. Code 370) | 2/6/04 28 Ill. Reg. 1931 | 4/20/04 |
| 5/9/04 | Department of Natural Resources, Public Use of | 2/6/04 | 4/20/04 |

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

| | | | |
|---|---|---|---|
| | State Parks and Other Properties of the Department of Natural Resources (17 Ill. Adm. Code 110) | 28 Ill. Reg. 1924 | |
| 5/9/04 | State Board of Education, Standards for Administrative Certification (23 Ill. Adm. Code 29) | 1/2/04 28 Ill. Reg. 249 | 4/20/04 |
| 5/9/04 | State Board of Education, Standards for Certification in Specific Teaching Fields (23 Ill. Adm. Code 27) | 1/2/04 28 Ill. Reg. 201 | 4/20/04 |
| 5/9/04 | State Board of Education, Secular Textbook Loan (23 Ill. Adm. Code 350) | 1/2/04 28 Ill. Reg. 278 | 4/20/04 |
| 5/9/04 | Department of Professional Regulation, Marriage and Family Therapy Licensing Act (68 Ill. Adm. Code 1283) | 11/21/03 27 Ill. Reg. 17354 | 4/20/04 |

PROCLAMATIONS

**2004-51**
**Loyalty Day**

WHEREAS, it is imperative that the American people take time to recognize the display of tremendous loyalty to their country exemplified by those that serve and have previously served in the United States Armed Forces; and

WHEREAS, Loyalty Day is a time to pay tribute to these men and women for their commitment to service, immense acts of bravery, and for the sacrifices they have made for our country, all so that we may remain free; and

WHEREAS, loyal citizens should make it their duty to inspire patriotism throughout their community, state and country by proudly flying the American flag; and

WHEREAS, we urgently need a vigorous display of true red, white and blue Americanism, which is one patriotic way of displaying the beliefs, ideals and convictions that unite Americans:

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim May 1, 2004 as LOYALTY DAY in Illinois, and encourage all citizens to observe this occasion by expressing your gratitude to the brave men and women of our Armed Forces for their dedication to protecting the freedoms that all Americans enjoy.

Issued by the Governor March 26, 2004.

Filed by the Secretary of State March 29, 2004.

**2004-52**
**National Association of Women Business Owners Day**

WHEREAS, the National Association of Women Business Owners (NAWBO) maintain more than 90 chapters in the United States; and

WHEREAS, the Chicago Area Chapter is among the largest with more than 600 members representing businesses in all major industrial, service, and retail sectors; and

WHEREAS, since 1978, Chicago NAWBO has provided women business owners with leadership, education, procurement, and networking opportunities. It also serves as a voice for its members on economic, social, and public policy issues; and

WHEREAS, currently, there are 278,000 women business owners in Illinois, with 70 percent of these businesses in the Chicagoland area; and

WHEREAS, NAWBO is an organization with a customer first philosophy that: strengthens the wealth creating capacity of its members and promotes economic development, creates innovative and effective changes in the business culture, builds strategic alliances, coalitions and affiliations, and transforms public policy and influences opinion makers; and

WHEREAS, NAWBO represents and gives women opportunities to expand and excel in the business world:

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim April 29, 2004 as the NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS DAY

in Illinois, and encourage all citizens to commemorate its 26 years of service to all women entrepreneurs.

Issued by the Governor March 26, 2004.

Filed by the Secretary of State March 29, 2004.

**2004-53**
**Arts In Education Spring Celebration Months**

WHEREAS, arts are the personification of beauty in the world, and help to preserve our cultural heritage; and

WHEREAS, the State of Illinois declares that arts education, which includes dance, drama, music and visual arts, is an essential part of basic instruction for all students, providing them with a balanced education that will aid in developing their full potential; and

WHEREAS, the Peoria County Regional Office of Education is committed to the establishment and continuation of school programs that provide students with the opportunity to achieve academic excellence; and furthermore, they are committed to supporting the development and promotion of fine and applied arts programs; and

WHEREAS, winner of several awards, the Arts in Education Spring Celebration is held at the Peoria County Courthouse and the Peoria Civic Center, and provides a venue for students in grades pre-Kindergarten through 12 to showcase their works and talents; and

WHEREAS, the 2003 Arts in Education Spring Celebration will be held April 19 through May 28, 2004; and

WHEREAS, the State of Illinois resolutely supports events such as the Arts in Education Spring Celebration, and commends the students and teachers who work to bring the beauty of art to this great state:

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim April and May 2004 as ARTS IN EDUCATION SPRING CELEBRATION MONTHS in Illinois.

Issued by the Governor March 26, 2004.

Filed by the Secretary of State March 29, 2004.

**2004-54**
**Cairo Programme of Action Tenth Anniversary Day**

WHEREAS, an estimated 515,000 women die every year – 98 percent of them in developing countries – as a result of pregnancy or childbirth; and

WHEREAS, every year, nearly 80 million unintended pregnancies occur worldwide, with more than half of them ending in abortion. An estimated 150 million women in developing countries say they would prefer to plan their families but are not using contraception, and another 350 million women lack access to effective family planning methods; and

WHEREAS, at least 30 to 40 percent of infant deaths are the result of poor care during pregnancy and delivery. These deaths could be avoided with improved maternal health, adequate nutrition and health care during pregnancy, and appropriate care during childbirth; and

WHEREAS, formed in 1994 in Cairo, Egypt, the Cairo Programme of Action is a promise to women and their children; and

WHEREAS, the Cairo Programme of Action reflected an historic global consensus of 179 countries and presented a concrete plan to save women's lives, and promote human dignity through family planning and reproductive health care services; and

WHEREAS, realizing these severe tragedies were due to a lack of education and reproductive freedom for women, the promise embodied in the Cairo Programme of Action is dedicated to providing love, shelter, education, and a healthy and clean environment for women throughout the world; and

WHEREAS, voluntary family planning and other reproductive health services can help couples avert high-risk pregnancies, prevent unwanted childbearing and abortion, and avoid diseases such as HIV/AIDS and other sexually transmitted infections, that can lead to death, disability, and infertility; and

WHEREAS the United States is a leader in human rights throughout the world and is committed to promoting the health, education and welfare of women and their families:

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim March 31, 2004 as CAIRO PROGRAMME OF ACTION TENTH ANNIVERSARY DAY in Illinois, and encourage all citizens to recognize the global consensus embodied in the Cairo Programme of Action, and commemorate its tenth anniversary.

Issued by the Governor March 26, 2004.

Filed by the Secretary of State March 29, 2004.

**2004-55**
**National Day of Prayer**

WHEREAS, in times of peril both at home and abroad, some American citizens turn to prayer for help and guidance; and

WHEREAS, these citizens ask for divine protection and blessing upon our land; and

WHEREAS, established in 1952 by an act of Congress, the National Day of Prayer is now observed nationally every year on the first Thursday in May; and

WHEREAS, the National Day of Prayer is a celebration of American citizens freedom of religion, set forth in the First Amendment; and

WHEREAS, the theme for the National Day of Prayer 2004 is Let Freedom Ring, inspired by the passage found in Leviticus 25:10: "…proclaim liberty throughout the land to all its inhabitants.":

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim May 6, 2004 as NATIONAL DAY OF PRAYER in Illinois.

Issued by the Governor March 26, 2004.

Filed by the Secretary of State March 29, 2004.

# ILLINOIS ADMINISTRATIVE CODE
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