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RULES OF GOVERNMENTAL AGENCIES

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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2009

Issue #	Rules Due Date	Date of Issue
1	December 22, 2008	January 2, 2009
2	December 29, 2008	January 9, 2009
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46	November 2, 2009	November 13, 2009
47	November 9, 2009	November 20, 2009
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50	November 30, 2009	December 11, 2009
51	December 7, 2009	December 18, 2009
52	December 14, 2009	December 28, 2009

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Permit Fees For Installing Or Extending Sewers

2) Code Citation: 35 Ill. Adm. Code 320

3)

Section Numbers:	Proposed Action:
320.101	Amended
320.102	Amended
320.103	Amended
320.104	Amended
320.201	Amended
320.202	Amended
320.301	Amended
320.302	Amended

4) Statutory Authority: Implementing and authorized by Section 12.2 of the Environmental Protection Act [415 ILCS 5/12.2]

5) A Complete Description of the Subjects and Issues Involved: This rulemaking will amend the Title of the Part and update the procedures the Agency uses to collect permit fees under Part 320 and the amounts of those fees in response to changes to Section 12.2 of the Environmental Protection Act.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

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

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objective: The proposed amendments do not create or enlarge a State mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b)].

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: The Illinois Environmental Protection Agency will accept written public

comments on this proposal for a period of 45 days after the date of publication in the *Illinois Register*. Comments should reference the Permit Fees For Installing Or Extending Sewers and be addressed to:

Deborah J. Williams
Illinois Environmental Protection Agency
1021 North Grand Avenue East
P.O. Box 19276
Springfield, IL 62794-9276

217/782-5544

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Any small business, small municipality or not-for-profit corporation that is required to obtain a permit from the Agency pursuant to Section 12(b) of the Environmental Protection Act may be impacted by this rulemaking.

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

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE C: WATER POLLUTION
CHAPTER II: ENVIRONMENTAL PROTECTION AGENCY

PART 320
~~PERMIT~~ FEES FOR CONSTRUCTION PERMITS REQUIRED UNDER SECTION 12(b) OF THE ILLINOIS ENVIRONMENTAL PROTECTION ACT~~INSTALLING OR EXTENDING SEWERS~~

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Section
320.301 Permit Applications Containing the Entire Fee
320.302 Permit Applications Not Containing the Entire Fee

AUTHORITY: Implementing and authorized by Section 12.2 of the Environmental Protection Act [415 ILCS 5/12.2].

SOURCE: Adopted at 17 Ill. Reg. 11461, effective July 8, 1993; amended at 33 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

Section 320.101 Definitions

a) Unless specified otherwise, all terms shall have the meaning set forth in the Act.

b) For purposes of this Part, the following definitions apply:

1) "Act" means the Environmental Protection Act ~~(Ill. Rev. Stat. 1991, ch. 111½, pars. 1001 et seq.)~~ [415 ILCS 5].

2) "Agency" means the Illinois Environmental Protection Agency.

3) "Applicant" means a person who applies for a construction permit to install or extend sewers, treatment works, industrial pretreatment works, or industrial wastewater source, pursuant to Title III of the Act or 35 Ill. Adm. Code~~:~~.Subtitle C or D.

4) "Design Population" means:

A) for purposes of new sewer systems, wasteload in terms of population equivalents contained within the proposed service area covered by the construction permit application;

B) for purposes of sewer extensions or connections, additional wasteload in terms of population equivalents contained within the service area added by the entire sewer proposed in the construction permit application.

5) "Fee" means the fee prescribed by Section 12.2 of the Act.

6) *"Industrial" refers to those industrial users referenced in* section 502(18) *of the federal Clean Water Act and regulations adopted pursuant to that Act.* (Section 12.2(h) of the Act)

7) "NPDES Permit" means National Pollutant Discharge Elimination System Permit.

8)~~6)~~ "Population Equivalent" means that one population equivalent is 100 gallons of sewage per day, containing 0.17 pounds of BOD5 (five day

biochemical oxygen demand) and 0.20 pounds of suspended solids, on the basis of the highest individual value of the three parameters.

9) *"Pretreatment" means the reduction of the amount of pollutants, the elimination of pollutants, or the alteration of the nature of pollutant properties in wastewater prior to or in lieu of discharging or otherwise introducing those pollutants into a publicly owned treatment works or publicly regulated treatment works.* (Section 12.2(h) of the Act)

10)~~7)~~ "Sewage" means water-carried human and related wastes from any source (35 Ill. Adm. Code 301.385).

11)~~8)~~ "Sewer" means a stationary means of transport, excluding natural waterways, constructed and operated primarily for the purpose of collecting and transporting sewage.

12) *"Toxic pollutants" means those pollutants defined in section 502(13) of the federal Clean Water Act and regulations adopted pursuant to that Act* (Section 12.2(h) of the Act). For purposes of this Part, this definition is limited to any pollutant listed as toxic pursuant to section 307(a)(1) of the Clean Water Act or in 40 CFR 122.21, Appendix D.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 320.102 Purpose

The purpose of this Part is to establish procedures for collecting fees from applicants for construction permits required~~collection of fees for construction permits from applicants for sewer construction permits~~ under ~~paragraph (b) of~~ Section 12(b) of the ~~Environmental Protection~~ Act.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 320.103 Applicability

a) Except as provided otherwise in subsection (c)~~(b) below~~, this Part applies to each applicant for a construction permit required under Title III of the Act, or 35 Ill. Adm. Code~~:~~ Subtitle C, to install or extend sewers.

b) Except as provided otherwise in subsection (c), this Part applies to each applicant for a construction permit required under Title III of the Act, or 35 Ill. Adm. Code.Subtitle C or D, to install or extend any treatment works, industrial pretreatment works, or industrial wastewater source. No fee shall be assessed under this Section if:

1) A treatment works or wastewater source is directly covered and authorized under an NPDES permit issued by the Agency;

2) A treatment works, industrial pretreatment works, or industrial wastewater source is under or pending construction authorized by a valid construction permit issued by the Agency prior to July 1, 2003 during the term of that construction permit; or

3) A treatment works, industrial pretreatment works, or industrial wastewater source for which a completed construction permit application has been received by the Agency prior to July 1, 2003 with respect to the permit issued under that application.

c~~b~~) Pursuant to Section 12.2(e) of the Act, this~~This~~ Part does not apply to:

1) Any *department*~~*Any Department*~~*, agency or unit of State government for installing or extending a sewer*;

2) Any~~*Any*~~ *unit of local government with which the Agency has entered into a written delegation agreement under* Section 4 of the Act~~*of the Act*~~ *which allows such unit to issue construction permits under* Title III of the Act,~~*Title III of the Act,*~~ *or regulations adopted thereunder, for installing or extending a sewer; or*

3) Any~~*Any*~~ *unit of local government or school district for installing or extending a sewer where both of the following conditions are met*:

A) The~~*The*~~ *cost of the installation or extension is paid wholly from monies of the unit of local government or school district, State grants or loans, federal grants or loans, or any combination thereof; and*

B) The~~*The*~~ *unit of local government or school district is not given*

monies, reimbursed or paid, either in whole or in part, by another person (except for State grants or loans or federal grants or loans) for the installation or extension. (Section 12.2(e) of the Act)

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 320.104 Relation to Other Fee Systems

Except as provided otherwise in Section 320.103(b) and (c), the~~The~~ fees collected pursuant to this Part, and the fee collection procedures set forth in this Part, are separate from and in addition to all other fees and fee systems established by law.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

SUBPART B: PROCEDURES FOR DETERMINATION AND PAYMENT OF FEES

Section 320.201 Amount of the Fee

a) Each applicant or person required to pay a fee under~~subject to~~ this Part pursuant to Section 320.103~~320.102~~ shall pay a fee to be submitted with the permit application. See 35 Ill. Adm. Code 370.Appendix A and 35 Ill. Adm. Code 370.Appendix B for guidance in determining design population.

b) The amount of fee for domestic sewer extensions is as follows:~~*The amount of fee is as follows:*~~

1) $100 for any domestic sewer constructed to serve a design population of 1;

2) $400 for any domestic sewer constructed to serve a design population of 2 to 20;

3) $800 for any domestic sewer constructed to serve a design population greater than 20 but less than 101;

4) $1,200 for any domestic sewer constructed to serve a design population of greater than 100 but less than 500; and

5) $2,400 for any domestic sewer constructed to serve a design population of 500 or more.

c) The amount of the fee for sources other than domestic sewer extensions is as follows:

1) $1,000 for any industrial wastewater source that does not require pretreatment of the wastewater prior to discharge to the publicly owned treatment works or publicly regulated treatment works;

2) $3,000 for any industrial wastewater source that requires pretreatment of the wastewater for non-toxic pollutants prior to discharge to the publicly owned treatment works or publicly regulated treatment works;

3) $6,000 for any industrial wastewater source that requires pretreatment of the wastewater for toxic pollutants prior to discharge to the publicly owned treatment works or publicly regulated treatment works; and

4) $2,500 for construction relating to land application of industrial sludge or spray irrigation of industrial wastewater.

~~1) *$50 for any sewer constructed to serve a design population of 1.*~~

~~2) *$200 for any sewer constructed to serve a design population of 2 to 20.*~~

~~3) *$400 for any sewer constructed to serve a design population greater than 20 but less than 100.*~~

~~4) *$600 for any sewer constructed to serve a design population of greater than 100 but less than 500.*~~

~~5) *$1,200 for any sewer constructed to serve a design population of 500 or more.*~~

d) The Agency shall deny any construction permit application that does not contain the appropriate fee as required in subsection (b) or (c).

e) *All fees collected by the Agency under this* Part *shall be deposited into the Environmental Protection Permit and Inspection Fund in accordance with Section 22.8* of the Act. (Section 12.2(c) of the Act)

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 320.202 Manner of Payment

a) Payment of the fee must be by certified or cashiers check for each permit application payable to "Treasurer, State of Illinois", designated to the Environmental Protection Permit and Inspection Fund with the applicant's Federal EmployerEmployee Identification Number (FEIN) or Social Security number appearing on the face of the check and shall be submitted along with the permit application to:

Illinois Environmental Protection Agency
Division of Water Pollution Control
1021 North Grand Avenue East2200 Churchill Road
Post Office Box 19276
Springfield, Illinois 62794-9276

b) Payment shall not include any fees due to the Agency for any purpose other than the fee due under Section 320.201 of this Part.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

SUBPART C: PROCEDURES FOR PROCESSING PERMIT APPLICATIONS

Section 320.301 Permit Applications Containing the Entire Fee

a) Applications received by the Agency will be logged in and assigned a receipt date and number. The application shall be accepted if the following conditions are met:

1) The application is complete in accordance with Title III of the Act and regulations adopted thereunder; and

2) The entire fee due under Section 320.201 of this Part is included with the application.

b) The*The* *Agency shall, not later than 45 days following the receipt* date assigned under subsection (a)*of both an application for a construction permit and the fee required by this* Part, *either approve that application and issue a permit or tender*

to the applicant a written statement setting forth with specificity the reasons for the disapproval of the application and denial of a permit in accordance with Sections 12.2 and 39(a) of the Act. *If the Agency takes ~~If there is~~ no final action ~~by the Agency~~ within 45 days after the filing of the application for a permit, the applicant may deem the permit issued.* (Section 12.2(g) of the Act) This 45 day deadline for Agency action may be waived by the applicant in writing.

c) *Prior to a final Agency decision on a permit application for which a fee has been paid under this* Part, *the applicant may propose modification to the application in accordance with* the*~~the~~ Act and regulations adopted* under the Act*~~thereunder~~ without any additional fee becoming due, unless the proposed modifications cause an increase in the design population served by the sewer specified in the permit application before the modifications or the modifications cause a change in the applicable fee category stated in* Section 320.201. *If the modifications cause such an increase or change the fee category and the increase results in additional fees being due under* Section 320.201~~ of this Part~~, *the applicant shall submit the additional fee to the Agency with the proposed modifications*. (Section 12.2(d) of the Act) If the applicant proposes a modification prior to a final Agency decision on the permit application, the 45 day review period described in subsection ~~Subsection 320.301~~(b)~~ above~~ shall commence on the date that the~~such~~ modification and any required fee pursuant to the modification, as provided in this subsection, is received.

d) If modifications to the permit application are received by the Agency from the applicant within 90 days after the date of permit denial in accordance with subsection (b)~~ of this Section~~, and if the~~such~~ modifications would allow approval of the application, a permit will be issued without additional fees becoming due under this Part, unless the proposed modifications cause an increase in the design population served by the sewer specified in the permit application before the modifications or the modifications cause a change in the applicable fee category stated in Section 320.201. If the modifications cause such an increase or change the fee category~~and the increase results in~~ additional fees will be~~being~~ due under Section 320.201~~ of this Part~~, and the applicant shall submit the additional fee to the Agency with the modifications.

e) If modifications to an existing permit are proposed before the date specified in the permit for completion of construction in accordance with the Act and regulations adopted under the Act~~thereunder~~, or before the expiration of the time limits provided in 35 Ill. Adm. Code 309.242(a) or 35 Ill. Adm. Code 404.109 if not

specified in the permit, and if thesuch modifications would allow approval of the application, a permit will be issued without additional fees becoming due under this Part, unless the proposed modifications cause an increase in the design population served by the sewer specified in the permit application before the modifications or the modifications cause a change in the applicable fee category stated in Section 320.201. If the modifications cause such an increase or change, the fee category additional fees will be due under Section 320.201 of this Part, and the applicant shall submit the additional fee to the Agency with the modifications.

f) Requests for extensions of permit expiration dates or requests for modifications to an existing permit other than those specified in this Section shall be considered new applications subject to the fees specified in Section 320.201 of this Part.

g) Except in those cases in whichwhere permit denial has been appealed to the Illinois Pollution Control Board in accordance with Section 40 of the Act, submissions received by the Agency more than 90 days after the date of permit denial in accordance with subsection (b) shall be considered new applications subject to the fees specified in Section 320.201 of this Part.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 320.302 Permit Applications Not Containing the Entire Fee

Applications not containing the entire fee shall be considered incomplete. The Agency shall take the following actions in response to such applications:

a) The Agency shall deposit any fees submitted along with the application and shall notify the applicant of the fee deficiency. Within 30 days after this notification, the applicant must submit the balance of the fee that is due.

1) If the entire fee due is received by the Agency within 30 days after issuance of the notice under subsection (a), the Agency shall accept the application in accordance with Section 320.301 of this Part.

2) If the required fee is not received within 30 days after the notice of deficiency, the permit shall be considered denied.

b) The 45 day review period described in Section 320.301(b) of this Part shall

commence on the date of acceptance assigned in accordance with Section 320.301(a) ~~of this Part~~.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Services

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

3)

Section Numbers:	Proposed Action:
148.117	Amendment
148.120	Amendment
148.122	Amendment
148.126	Amendment
148.130	Amendment
148.295	Amendment
148.296	Amendment
148.297	Amendment
148.460	New Section

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 95-1017

5) Complete Description of the Subjects and Issues Involved: The Department proposes changes to reimbursement programs to include Critical Hospital Access Payment (CHAP), Safety Net Adjustment Payments (SNAP), Outpatient Assistance Adjustment Payment, Pediatric Outpatient Adjustment Payments, and Tertiary Care Adjustment Payments, which will result in $35 million in annual spending. The proposal also makes an adjustment to the Hospital Outlier calculation to allow all children's hospitals to qualify for such payments as identified in 89 Ill. Adm. Code 149.50(c)(3)(B). It is estimated that this adjustment will result in an additional $4 million to hospital providers meeting this criteria. Lastly this rulemaking adds a new Section pursuant to P.A. 95-1017, which will provide $40 million in catastrophic relief payments to hospitals in FY09.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

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

9) Does this rulemaking contain incorporations by reference? No

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

12) 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:

Tamara Tanzillo Hoffman
Chief of Staff
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/557-7157

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.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded provider hospitals

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: January 2009

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

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SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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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 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
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148.295 Critical Hospital Adjustment Payments (CHAP)
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148.297 Pediatric Outpatient Adjustment Payments
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148.300 Payment
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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)
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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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148.600 Definitions
148.610 Scope of the Program
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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 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; emergency expired June 7, 2004; 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; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of

150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; peremptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; amended at 33 Ill. Reg. _____, effective _____.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.117 Outpatient Assistance Adjustment Payments

a) Qualifying Criteria. Outpatient Assistance Adjustment Payments, as described in subsection (b) of this Section, shall be made to Illinois hospitals meeting one of the criteria identified in this subsection (a):

1) A hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 70% and has provided greater than 10,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

2) A general acute care hospital that qualifies for Disproportionate Share Adjustment Payments for rate year 2007, as defined in Section 148.120, has an emergency care percentage greater than 85%.

3) A general acute care hospital that does not qualify for Medicaid Percentage Adjustment Payments for rate year 2007, as defined in Section 148.122, located in Cook County, outside the City of Chicago, has an emergency care percentage greater than 63%, has provided more than 10,750 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year and has provided more than 325 Medicaid surgical group outpatient ambulatory procedure listing services in the outpatient assistance base year.

4) A general acute care hospital located outside of Cook County that qualifies for Medicaid Percentage Adjustment Payments for rate year 2007 as defined in Section 148.122, is a trauma center recognized by the Illinois Department of Public Health (IDPH) as of July 1, 2006, has an emergency care percentage greater than 58%, and has provided more than 1,000 Medicaid Non-emergency/Screening outpatient ambulatory procedure listing services in the outpatient assistance base year.

5) A hospital that has an MIUR of greater than 50% and an emergency care percentage greater than 80%, and that provided more than 6,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

6) A hospital that has an MIUR of greater than 70% and an emergency care percentage greater than 90%.

7) A general acute care hospital, not located in Cook County, that is not a trauma center recognized by IDPH as of July 1, 2006 and did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an MIUR of greater than 25% and an emergency care percentage greater than 50%, and that provided more than 8,500 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

8) A general acute care hospital, not located in Cook County, that is a Level I trauma center recognized by IDPH as of July 1, 2006, has an emergency

care percentage greater than 50%, and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services, including more than 1,000 non-emergency screening outpatient ambulatory procedure listing services, in the outpatient assistance base year.

9) A general acute care hospital, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Section 148.122, has an emergency care percentage greater than 55%, and provided more than 12,000 Medicaid outpatient ambulatory procedure listing services, including more than 600 surgical group outpatient ambulatory procedure listing services and 7,000 emergency services in the outpatient assistance base year.

10) A general acute care hospital that has an emergency care percentage greater than 75% and provided more than 15,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

11) A rural hospital that has an MIUR of greater than 40% and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

12) A general acute care hospital, not located in Cook County, that is a trauma center recognized by IDPH as of July 1, 2006, had more than 500 licensed beds in calendar year 2005, and provided more than 11,000 Medicaid outpatient ambulatory procedure listing services, including more than 950 surgical group outpatient ambulatory procedure listing services, in the outpatient assistance base year.

b) Outpatient Assistance Adjustment Payments

1) For hospitals qualifying under subsection (a)(1), the rate is $139.00.

2) For hospitals qualifying under subsection (a)(2), the rate is $850.00~~$336.25~~.

3) For hospitals qualifying under subsection (a)(3), the rate is $425.00~~$200.25~~.

4) For hospitals qualifying under subsection (a)(4), the rate is $375.00~~$217.25~~.

5) For hospitals qualifying under subsection (a)(5), the rate is $250.00.

6) For hospitals qualifying under subsection (a)(6), the rate is $336.25.

7) For hospitals qualifying under subsection (a)(7), the rate is $110.00

8) For hospitals qualifying under subsection (a)(8), the rate is $200.00.

9) For hospitals qualifying under subsection (a)(9), the rate is $48.50.

10) For hospitals qualifying under subsection (a)(10), the rate is $135.00.

11) For hospitals qualifying under subsection (a)(11), the rate is $65.00.

12) For hospitals qualifying under subsection (a)(12), the rate is $90.00.

c) Payment to a Qualifying Hospital

1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the outpatient assistance adjustment base year.

2) For the outpatient assistance adjustment period for fiscal year 2009 and after, total payments will equal the amount determined using the methodologies described in subsection (c)(1) of this Section and shall be paid to the hospital, at least, on a quarterly basis.

3) Payments described in subsections (b)(5) through (b)(12) of this Section are contingent upon approval of federal funding for such payments.

d) Definitions

1) "Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C), excluding services for individuals eligible for

Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006.

2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in 89 Ill. Adm. Code 149.50(c).

3) "Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services as described in Section 148.140(b)(1), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

4) "Outpatient assistance year" means, beginning January 1, 2007, the 6-month period beginning on January 1, 2007 and ending June 30, 2007, and beginning July 1, 2007, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

5) "Outpatient assistance base period" means the 12-month period beginning on July 1, 2004 and ending June 30, 2005.

6) "Surgical group outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(A), excluding services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

7) "Non-emergency/screening outpatient ambulatory procedure listing services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b)(1)(C)(iii), excluding services for individuals eligible for Medicare under Title XVIII of the Act

(Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through June 30, 2006.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter unless otherwise noted.

a) Qualified Disproportionate Share Hospitals (DSH). For inpatient services provided on or after October 1, 2003, the Department shall make adjustment payments to hospitals thatwhich are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in subsection (k)(4) of this Section, is at least one standard deviation above the mean Medicaid utilization rate, as defined in subsection (k)(3) of this Section.

2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.

b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a

hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

c) In making the determination described in subsection (a)(1) of this Section, the Department shall utilize:

1) Hospital Cost Reports

A) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (k)(4) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

B) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (a)(1) of this Section. Submittal of a corrected cost report in support of subsection (a)(1) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's MIUR as described in subsection (k)(4) of this Section.

C) In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.

i) If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination.

ii) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or unaudited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30.

D) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (k)(4) of this Section, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsections (c)(1)(B) and (c)(1)(C)(ii) of this Section, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.

E) In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (k)(4) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH

determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.

2) Days Not Available from Cost Report
Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid Health Maintenance Organization (HMO) days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse rehabilitative care under category of service 35. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims.

i) For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (c)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.

ii) For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a

hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) HMO days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each HMO, for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

E) Alcohol and Substance Abuse Days. The Department will utilize its paid claims data under category of service 35 available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided for alcohol and substance abuse rehabilitative care.

d) Hospitals may apply for DSH status under subsection (a)(2) of this Section by submitting an audited certified financial statement, for the hospital's base fiscal year, to the Department of Human Services or the Department of Public Aid. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance), for the hospital's base fiscal year.

4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR , as described in subsection (k)(4) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the MIUR from their state may submit an audited certified financial statement as described in subsection (d) of this Section. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g) of this Section.

f) Time Limitation Requirements for Additional Information.

1) Except as provided in subsection (c)(1)(C), the information required in subsections (a), (c), (d) and (e) of this Section must be received or post marked no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in subsections (a), (c), (d) and (e) of this Section which is not received or post marked in compliance with these limitations will not be considered

for the determination of those hospitals qualified for DSH adjustments.

2) The information required in subsection (b) of this Section must be submitted after receipt of notification from the Department. Information required in this Section that~~which~~ is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) of this Section shall be calculated annually as follows:

1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1), with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.

A) Hospitals qualifying as DSH hospitals under subsection (a)(1) or (a)(2) of this Section will receive an add-on payment to their inpatient rate.

B) The distribution method for the add-on payment described in subsection (g)(1) of this Section is based upon a fund of $5 million. All hospitals qualifying under subsection (g)(1)(A) of this Section will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) of this Section in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (k)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year

Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) of this Section, plus the initial $5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) of this Section, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2) of this Section will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection (g)(1) are subject to the limitations described in subsection (j) of this Section. The adjustments calculated under subsection (g) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

2) Department of Human Services (DHS) State-Operated Facility Adjustment for hospitals defined in Section 148.25(b)(6). Department of Human Services State-operated facilities qualifying under subsection (a)(2) of this Section shall receive an adjustment for inpatient services provided on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be calculated as follows:

A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be the lesser of the federal DSH allotment for mental health facilities as determined in section 1923(h) of the Social Security Act, minus the estimated DSH payments to such facilities that are not operated by the State; or the result of subtracting the estimated DSH payment adjustments made under subsections (g)(1), (h) and (i) of this Section and Section 148.170(f)(2) from the aggregate DSH payment allotment as provided for in section 1923(f) of the Social Security Act.

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(b)(6) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.

C) The adjustment calculated in subsection (g)(2)(B) of this Section shall meet the limitation described in subsection (j)(4) of this Section.

D) The adjustment calculated pursuant to subsection (g)(2)(B) of this Section, for each hospital defined in Section 148.25(b)(6) that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (j) of this Section. The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.

3) Assistance for Certain Public Hospitals

A) The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year. A qualifying hospital is a public hospital as defined in section 701(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554).

B) Hospitals qualifying shall receive an annual payment adjustment that is equal to:

i) A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, section 701(d)(3)(B) for the DSH determination year;

ii) Divided first by Illinois' Federal Medical Assistance Percentage; and

iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection

(k)(4) of this Section; and

iv) Multiplied by each qualified hospital's Medicaid inpatient days as defined in subsection (k)(4) of this Section.

C) The annual payment adjustment calculated under this subsection, for each qualified hospital, will be divided by four and paid on a quarterly basis.

D) Payment adjustments under this subsection (g)(3) shall be made without regard to subsections (j)(3) and (4) of this Section, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

E) In order to qualify for assistance payments under this subsection (g)(3), with regard to this payment adjustment, there must be in force an executed intergovernmental agreement between the authorized governmental body of the qualifying hospital and the Department.

h) Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustments calculated under Section 148.122 shall be considered disproportionate share adjustments.

i) For county owned hospitals defined in Section 148.25(b)(1)(A), a portion of the payments made in accordance with Sections 148.160(f)(3) and 148.295(c)(2)(J) may be considered disproportionate share adjustments.

j) DSH Adjustment Limitations.

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (j)(1) shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of

December 22, 1987. In this instance, the adjustments calculated under subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the federal Centers for Medicare and Medicaid Services~~Health Care Financing Administration (HCFA)~~, DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. This adjustment shall first be applied to DSH payments made under subsection (g)(2) of this Section. The annual amount shall be paid to the hospital in monthly installments. The portion of the annual amount not paid pending federal approval of payments shall, upon that approval, be paid in a single lump sum payment. Except as indicated in this subsection (j)(3), the annual amount shall be paid to the hospital in 12 equal installments and paid monthly. Subject to any limitation, disproportionate share payments will be made to qualifying hospitals in the following order:

A) Psychiatric hospitals operated by the Illinois Department of Human Services – the annual amount shall be credited quarterly via certification of public expenditure.

B) Hospitals defined in Section 148.25(b)(1)(B).

C) Hospitals owned and operated by a unit of local government that is not a hospital defined in Section 148.25(b)(1)(A).

D) Hospitals that are not owned or operated by a unit of government – the annual amount shall be paid on each inpatient claim.

E) Hospitals defined in Section 148.25(b)(1)(A).

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93 adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (j)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.

5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's MIUR, as defined in subsection (k)(4)of this Section, is less than one percent.

k) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 2001 for the October 1, 2003 DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004 DSH determination year, etc.

2) "DSH determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the

Federal Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section. In this subsection (k)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12 month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 USC 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section. In this subsection (k)(4), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.122 Medicaid Percentage Adjustments

The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1 thereafter unless otherwise noted.

a) Qualified Medicaid Percentage Hospitals. For inpatient services provided on or after October 1, 2003, the Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital, except those that are owned or operated by a unit of government, may qualify for a Medicaid Percentage Adjustment in one of the following ways:

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1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(k)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(k)(3).

2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.

3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(k)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5 (1989)).

4) Illinois hospitals that:

   A) Have an MIUR, as defined in Section 148.120(k)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3); and

   B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (gh)(3) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (gh)(2) of this Section.

5) Any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3).

6) Out of state hospitals meeting the criteria in Section 148.120(e).

b) In making the determination described in subsections (a)(1) and (a)(4)(A) of this Section, the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f).

c) Hospitals may apply to become a qualified Medicaid Percentage Adjustment hospital under subsection (a)(2) of this Section by submitting audited certified financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) of this Section for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section 148.25(b)(1)(A) and (b)(1)(B).

1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(k)(4), and subject to subsection~~subsections~~ (e) ~~and (f)~~ of this Section, as follows:

A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;

C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one

percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

2) The Medicaid Percentage Adjustment payment, calculated in accordance with this subsection (d), to a hospital, other than a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed $155 per day for a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), and shall not exceed $215 per day for all other hospitals.

3) The amount calculated pursuant to subsections (d)(1) through (d)(2) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(k)(2), through DSH determination year 2003, and annually thereafter, by a percentage equal to the lesser of:

A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

B) The percentage increase in the Statewide average hospital payment rate, as described in subsection (g~~h~~)(5) of this Section, over the previous year's Statewide average hospital payment rate.

4) The amount calculated pursuant to subsections (d)(1) through (d)(3) of this Section, as adjusted pursuant to subsection~~subsections~~ (e) ~~and (f)~~ of this Section, shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(3) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), the payment adjustment calculated under subsection (d)(1) of this Section shall be multiplied by 2.0.

~~f) DSH for Government-Owned or Operated Hospitals.~~

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~~1)~~ ~~The following classes of government-owned or operated Illinois hospitals shall, subject to the limitations set forth in subsection (g) of this Section, be eligible for the Disproportionate Share Hospital Adjustment payment:~~

~~A)~~ ~~Hospitals defined in Section 148.25(b)(1)(A).~~

~~B)~~ ~~Hospitals owned or operated by a unit of local government that is not a hospital defined in subsection (f)(1)(A) of this Section.~~

~~C)~~ ~~Hospitals defined in Section 148.25(b)(1)(B).~~

~~2)~~ ~~The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations, adjusted from the midpoint of the cost report period to the midpoint of the rate period using the CMS Hospital Price Index.~~

~~3)~~ ~~The annual amount shall be paid to the hospital in monthly installments. The portion of the annual amount not paid pending federal approval of payments shall, upon that approval, be paid in a single lump sum payment. The annual amount shall be paid to the hospital in 12 equal installments and paid monthly.~~

f)~~g)~~ Medicaid Percentage Adjustment Limitations.

1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of non-emergency obstetrical care. The provisions of this subsection (fg)(2) shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered non-emergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.

4) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(k)(4), is less than one percent.

g)~~h)~~ Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:

1) "Medicaid Percentage determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g~~h~~)(4) of this Section, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of

the Federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (gh)(6) of this Section, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (gh)(4) of this Section, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (gh)(6) of this Section, provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.

4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage Adjustment determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with a Diagnosis Related Grouping (DRG) of 370 through 375, and specifically excludes Medicare/Medicaid crossover claims.

5) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

6) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (gh)(2) and (gh)(3) of this Section, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid

claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

7) "Medicaid obstetrical inpatient utilization rate base year" means, for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year; etc.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.126 Safety Net Adjustment Payments

a) Qualifying criteria: Safety net adjustment payments shall be made to a qualifying hospital, as defined in this subsection (a), unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006. A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria:

1) The hospital has, as provided in subsection (e)(6) of this Section, an MIUR equal to or greater than 40 percent.

2) The hospital has the highest number of obstetrical care days in the safety net hospital base year.

3) The hospital is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).

4) The hospital is, as of October 1, 2001, a rural hospital, as described in Section 148.25(g)(3), that meets all of the following criteria:

A) Has an MIUR greater than 33 percent.

B) Is designated a perinatal level two center by the Illinois Department of Public Health.

C) Has fewer than 125 licensed beds.

5) The hospital is a rural hospital, as described in Section 148.25(g)(3).

6) The hospital meets all of the following criteria:

A) Has an MIUR greater than 30 percent.

B) Had an occupancy rate greater than 80 percent in the safety net hospital base year.

C) Provided greater than 15,000 total days in the safety net hospital base year.

7) The hospital meets all of the following criteria:

A) Does not already qualify under subsections (a)(1) through (a)(6) of this Section.

B) Has an MIUR greater than 25 percent.

C) Had an occupancy rate greater than 68 percent in the safety net hospital base year.

D) Provided greater than 12,000 total days in the safety net hospital base year.

8) The hospital meets all of the following criteria in the safety net base year:

A) Is a rural hospital, as described in Section 148.25(g)(3).

B) Has an MIUR greater than 18 percent.

C) Has a combined MIUR greater than 45 percent.

D) Has licensed beds less than or equal to 60.

E) Provided greater than 400 total days.

F) Provided fewer than 125 obstetrical care days.

9) The hospital meets all of the following criteria in the safety net base year:

A) Is a psychiatric hospital, as described in 89 Ill. Adm. Code 149.50(c)(1).

B) Has licensed beds greater than 120.

C) Has an average length of stay less than ten days.

10) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(9) of this Section.

B) Has an MIUR greater than 17 percent.

C) Has licensed beds greater than 450.

D) Has an average length of stay less than four days.

11) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(10) of this Section.

B) Has an MIUR greater than 21 percent.

C) Has licensed beds greater than 350.

D) Has an average length of stay less than 3.15 days.

12) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(11) of this Section.

B) Has an MIUR greater than 34 percent.

C) Has licensed beds greater than 350.

D) Is designated a perinatal Level II center by the Illinois Department of Public Health.

13) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(12) of this Section.

B) Has an MIUR greater than 35 percent.

C) Has an average length of stay less than four days.

14) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(13) of this Section.

B) Has a CMIUR greater than 25 percent.

C) Has an MIUR greater than 12 percent.

D) Is designated a perinatal Level II center by the Illinois Department of Public Health.

E) Has licensed beds greater than 400.

F) Has an average length of stay less than 3.5 days.

15) A hospital provider that would otherwise be excluded from payment by subsection (a) because it does not operate a comprehensive emergency room, if the hospital provider operates within 1 mile of an affiliate hospital provider that is owned and controlled by the same governing body that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), and the provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider.

16) The hospital has an MIUR greater than 90% in the safety net hospital base year.

17) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(16) of this Section.

B) Is located outside HSA 6.

C) Has an MIUR greater than 16%.

D) Has licensed beds greater than 475.

E) Has an average length of stay less than five days.

18) The hospital meets all of the following criteria in the safety net base year:

A) Provided greater than 5,000 obstetrical care days.

B) Has a combined MIUR greater than 80%.

19) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(18) of this Section.

B) Has a CMIUR greater than 28 percent.

C) Is designated a perinatal Level II center by the Illinois Department of Public Health.

D) Has licensed beds greater than 320.

E) Had an occupancy rate greater than 37 percent in the safety net hospital base year.

F) Has an average length of stay less than 3.1 days.

b) The following five classes of hospitals are ineligible for safety net adjustment payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4), subsections (a)(6) through (a)(8), subsections (a)(10) through (a)(15) and subsections (a)(17) through (a)(19)~~(18)~~ of this Section:

1) Hospitals located outside of Illinois.

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

3) Hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B).

4) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).

5) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).

c) Safety Net Adjustment Rates

1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:

A) A qualifying hospital – $15.00.

B) A rehabilitation hospital, as described in 89 Ill. Adm. Code 149.50(c)(2) – $20.00.

C) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3) – $20.00.

D) A children's hospital that has an MIUR greater than or equal to 80 per centum that is:

i) Located within HSA 6 or HSA 7 – $296.00.

ii) Located outside HSA 6 or HSA 7 – $35.00.

E) A children's hospital that has an MIUR less than 80 per centum,

but greater than or equal to 60 per centum, that is:

i) Located within HSA 6 or HSA 7 – $35.00.

ii) Located outside HSA 6 or HSA 7 – $15.00.

F) A children's hospital that has an MIUR less than 60 per centum, but greater than or equal to 45 per centum, that is:

i) Located within HSA 6 or HSA 7 – $12.00.

ii) Located outside HSA 6 or HSA 7 – $5.00.

G) A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory" – $160.25.

H) A children's hospital that is a rural hospital – $145.00.

I) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital that is located in HSA 6 and that:

i) Provides obstetrical care – $10.00.

ii) Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – $5.00.

iii) Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – $5.00.

iv) Provided more than 5,000 obstetrical days during the safety net hospital base year – $35.00.

v) Provided fewer than 4,000 obstetrical days during the safety net hospital base year and its average length of stay is: less than or equal to 4.50 days – $5.00; less than 4.00 days – $5.00; less than 3.75 days – $5.00.

vi) Provides obstetrical care and has an MIUR greater than 65 percent – $11.00.

vii) Has greater than 700 licensed beds – $37.75.

J) A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centum, and that:

i) Provides obstetrical care – $280.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $70.00.

ii) Does not provide obstetrical care – $120.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $30.00.

iii) Is a trauma center, recognized by the Illinois Department of Public Health (IDPH), as of July 1, 2005 – $173.50.

K) A qualifying hospital that provided greater than 35,000 total days in the safety net hospital base year – $43.25.

L) A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay fewer than 4.00 days – $48.00.

2) For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be $123.00.

3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is the sum of the amounts for each of the following criteria for which it qualifies:

A) A qualifying hospital – $40.00.

B) A hospital that has an average length of stay of fewer than 4.00

days, and:

i) More than 150 licensed beds – $20.00.

ii) Fewer than 150 licensed beds – $40.00.

C) A qualifying hospital with the lowest average length of stay – $15.00.

D) A hospital that has a CMIUR greater than 65 per centum – $35.00.

E) A hospital that has fewer than 25 total admissions in the safety net hospital base year – $160.00.

4) For a hospital qualifying under subsection (a)(4) of this Section, the rate shall be $110.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $55.00.

5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is the sum of the amounts for each of the following for which it qualifies, divided by the hospital's total days:

A) The hospital that has the highest number of obstetrical care admissions – $30,840.00.

B) The greater of:

i) The product of $115.00 multiplied by the number of obstetrical care admissions.

ii) The product of $11.50 multiplied by the number of general care admissions.

6) For a hospital qualifying under subsection (a)(6) of this Section, the rate is $56.00 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $53.00.

7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is $210.50 if federal approval is received by the Department for such a rate;

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otherwise, the rate shall be $175.50.

8) For a hospital qualifying under subsection (a)(8) of this Section, the rate is $124.50.

9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is $85.50.

10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is $13.75.

11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is $200.00 for dates of service on or after April 1, 2009 through June 30, 2010. For dates of service on or after July 1, 2010, the rate is $39.50.

12) For a hospital qualifying under subsection (a)(12) of this Section, the rate is $240.50 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $120.25.

13) For a hospital qualifying under subsection (a)(13) of this Section, for dates of service on or after April 1, 2009, the rate is $815.00~~$231.50~~.

14) For a hospital qualifying under subsection (a)(14) of this Section, the rate is $443.75 if federal approval is received by the Department for such a rate; otherwise, the rate shall be $343.75.

15) For a hospital qualifying under subsection (a)(16) of this Section, the rate is $39.50.

16) For a hospital qualifying under subsection (a)(17) of this Section, the rate is $69.00. This reimbursement rate is contingent on federal approval.

17) For a hospital qualifying under subsection (a)(18) of this Section, the rate is $16.00. This reimbursement rate is contingent on federal approval.

18) For a hospital qualifying under subsection (a)(19) of this Section, for dates of service on or after April 1, 2009, the rate is $145.00.

d) Payment to a Qualifying Hospital

1) The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.

2) For the safety net adjustment period occurring in State fiscal year 2008, total payments will be determined through application of the methodologies described in subsection (c) of this Section.

3) For safety net adjustment periods occurring after State fiscal year 2008, total payments made under~~will equal sum of amounts calculated under the methodologies described in subsection (c) of~~ this Section ~~and~~ shall be paid ~~to the hospital during the safety net adjustment period~~ in installments on, at least, a quarterly basis.

e) Definitions

1) "Average length of stay" means, for a given hospital, a fraction in which the numerator is the number of total days and the denominator is the number of total admissions.

2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section 148.120(k)(6).

3) "General care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in subsection (e)(7) of this Section; normal newborns; psychiatric care; physical rehabilitation; and those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions).

4) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.

5) "Licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July

25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

6) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(k)(5) 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 2002 shall be the same determination used to determine a hospital's eligibility for safety net adjustment payments in the Safety Net Adjustment Period.

7) "Obstetrical care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data, for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001, and were assigned by the Department a diagnosis related grouping (DRG) code of 370 through 375.

8) "Obstetrical care days" means, for a given hospital, days of hospital inpatient service associated with the obstetrical care admissions described in subsection (e)(7) of this Section.

9) "Occupancy rate" means, for a given hospital, a fraction, the numerator of which is the hospital's total days, excluding long term care and substance abuse days, and the denominator of which is the hospital's total beds, excluding long term care and substance abuse beds, multiplied by 365 days. The data used for calculation of the hospital occupancy rate is as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".

10) "Safety net hospital base year" means the 12-month period beginning on July 1, 1999, and ending on June 30, 2000.

11) "Safety net adjustment period" means, beginning July 1, 2002, the 12 month period beginning on July 1 of a year and ending on June 30 of the following year.

12) "Total admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

13) "Total 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 claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department through June 30, 2001.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.130 Outlier Adjustments for Exceptionally Costly Stays

a) Outlier Adjustments. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g).

b) The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section 148.25(g)(2)(B), for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g):

1) The services must have been provided on or after October 1, 1992; and

2) The services must have been provided to:

A) Children who have not attained the age of six years by hospitals defined by the Department as DSH hospitals under Section 148.120(a); or

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B) Infants who have not attained the age of one year by hospitals that do not meet the definition of a DSH hospital under Section 148.120(a); or

C) Children who have not attained the age of 19 on the date of admission for services provided~~Provided~~ on or after January 1, 2008~~,~~ by a hospital devoted exclusively to the care of children as defined in 89 Ill. Adm. Code 149.50(c)(3)(A); or~~, to children who have not attained the age of 19 on the date of admission.~~

D) Children who have not attained the age of 19 on the date of admission for services provided on or after July 1, 2009 by a Children's Hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(B).

3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

A) Total covered charges (less charges attributable to medical education) equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of subsection (b)(3)(B) shall be subtracted from the product of subsection (b)(3)(A).

D) The difference of subsection (b)(3)(C) shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party payments (credits) shall be applied to the final payment made on the claim.

c) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.

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d) Definition of terms relating to outlier adjustments are as follows:

1) "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.

2) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.

3) "Mean total covered charges" means the mean total covered charges (as described in subsection (d)(5)), for services provided in the most recent state fiscal year for which complete information is available and which have been adjudicated by the Department, as follows:

A) For hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and

B) For hospitals defined by the Department as DSH hospitals under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.

4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.

5) "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

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

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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)
The Department shall make a TCA to 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)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(c)(3), operating under the same license as a hospital designated as a trauma center, shall be deemed to be a trauma center.

1) Level I Trauma Center Adjustment.

A) Criteria. Hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by IDPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection (a)(2) are not eligible for payment under this subsection.

B) Adjustment. 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 I Trauma Center Adjustment for hospitals located in the same city, that alternate their Level I trauma center designation.

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A) Criteria. Hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their designation as a Level I trauma center by the Illinois Department of Public Health is rotated among qualifying hospitals from year to year or during a year, that are in the following classes:

i) A children's hospital − All children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3), in a given city, qualifying under subsection (a)(2)(A) shall be considered one entity for the purpose of calculating the adjustment in subsection (a)(2)(B).

ii) A general acute care hospital − All general acute care adult hospitals, in a given city, affiliated with a children's hospital, as defined in subsection (a)(2)(A)(i), qualifying under subsection (a)(2)(A) shall be considered one entity for the purposes of calculating the adjustment in subsection (a)(2)(B).

B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(2)(A) shall receive an adjustment as follows:

i) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of $5,250.00 per Medicaid trauma admission for that class, in the CHAP base period.

ii) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is less than the mean Medicaid trauma admissions of the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of $3,625.00 per Medicaid trauma admission for that class in the CHAP base period.

3) Level II Rural Trauma Center Adjustment. 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.

4) Level II Urban Trauma Center Adjustment. 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)(4) 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)(4) of this Section; and

C) The hospital does not qualify under subsection (a)(2).

5) In determining annual payments that are pursuant to the Trauma Center Adjustments as described in this Section, for the CHAP rate period occurring in State fiscal year 2009, total payments will equal the methodologies described in this Section. For the period December 1, 2008 to June 30, 2009, payment will equal the State fiscal year 2009 amount less the amount the hospital received for the period July 1, 2008 to November 30, 2008.

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 unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:

   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.

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.

I) 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)(H) of this Section, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 Total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.

J) A hospital that does not qualify under subsection (c)(1) of this Section because it does not operate a comprehensive emergency room will qualify if the hospital provider operates a standby emergency room, as defined in 77 Ill. Adm. Code 250.710(c), and functions as an overflow emergency room for its affiliate hospital provider, owned and controlled by the same governing body, that operates a comprehensive emergency room, as defined in 77 Ill. Adm. Code 250.710(a), within one mile of the hospital provider.

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 $354.00~~$330.00~~ per day for dates of service on or after April 1, 2009.

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 $131.00~~$41.00~~ per day for dates of service on or after April 1, 2009.

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 $360.00~~$227.00~~ per day for dates of service on or after April 1, 2009.

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 $650.00~~$528.00~~ per day for dates of service on or after April 1, 2009.

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 $320.50 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 $185.00~~$98.00~~ per day for dates of service on or after April 1, 2009.

xii) Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by $148.00 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 $600~~$369.00~~ per day for dates of service on or after April 1, 2009 through June 30, 2010. For dates of service on or after July 1, 2010, the rate is $369.00.

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 $328.00 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 $191.00~~$110.25~~ per day for dates of service on or after April 1, 2009.

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 per day.

ii) Hospitals with an MIUR equal to or less than 19.75 percent, will receive a rate of $11.00 per day.

I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day.

J) Hospitals qualifying under subsection (c)(1)(I) of this Section will receive a rate of $328.00 per day if federal approval is received by the Department for such a rate; otherwise, the rate shall be $238.00 per day.

K) 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 Adjustmentsi)~~For the CHAP rate period occurring in State fiscal year 2008, total payments will equal the methodologies described in subsection (c)(2) of this Section.~~ii)For CHAP rate periods occurring after State fiscal year 2008, 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. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under subsection (a)(2).

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, 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 839.31, 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 through 925.2, 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.

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 at 33 Ill. Reg. _____, effective _____)

Section 148.296 Tertiary Care Adjustment Payments

Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), 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, 2002, in accordance with this Section.

a) Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:

1) "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in 89 Ill. Adm. Code 149.50(c)(3), be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:

A) Claims for which Medicare was liable in part or in full ("cross-over" claims);

B) Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and

C) Claims for services billed for exceptional care services as described at Section 148.50(c)(2)(A) and (B).

2) "Case Mix Index" or "~~(~~CMI"~~)~~, for a given hospital, means the sum of all Diagnosis Related Grouping (DRG) (see 89 Ill. Adm. Code 149) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:

A) Reimbursed under a per diem rate methodology; and

B) For Delivery or Newborn Care.

3) "Case Mix Adjustment Factor" or "~~(~~CMAF"~~)~~ means the following:

A) For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:

i) CMI of all Illinois cost-reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;

ii) CMI plus one standard deviation above the mean of all Illinois cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;

iii) CMI plus two standard deviations above the mean of all Illinois cost reporting hospitals, the CMAF shall be equal to 0.300.

B) For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:

i) CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;

ii) CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean

plus two standard deviations above the mean, the CMAF shall be equal to 0.125;

iii) CMI plus two standard deviations above the mean of all out-of-state cost reporting hospitals, the CMAF shall be equal to 0.150.

4) "Delivery or Newborn Care" means inpatient hospital care, the claim for which was assigned by the Department to DRGs 370 through 375, 385 through 387, 389, 391 and 985 through 989.

5) "Tertiary Adjustment Base Period" means calendar year 1998.

6) "Tertiary Care Adjustment Rate Period" means, for fiscal year 2001, the three-month period beginning April 1, 2001, and for each subsequent fiscal year, the twelve-month period beginning July 1.

b) Case Mix Adjustment
The Department shall make a Case Mix Adjustment to certain hospitals, as defined in this subsection (b).

1) Qualifying Hospital. A hospital meeting both of the following criteria shall qualify for this payment:

A) A hospital that had 100 or more Qualified Admissions; and

B) For a hospital located:

i) in Illinois, has a CMI greater than or equal to the mean CMI for Illinois hospitals; or

ii) outside of Illinois, has a CMI greater than or equal to the mean CMI for out-of-state cost-reporting hospitals.

2) Qualified Admission. For the purposes of this subsection (b), "Qualified Admission" shall mean a Base Period Claim excluding a claim:

A) Reimbursed under a per diem rate methodology; and

B) For Delivery or Newborn Care.

3) Case Mix Adjustment. Each Qualifying Hospital will receive a payment equal to the product of:

A) The product of the hospital's:

i) number of Qualified Admissions; and

ii) CMAF; and

B) The sum of the hospital's:

i) rate for capital related costs in effect on July 1, 2000; and

ii) the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see 89 Ill. Adm. Code 149) rate per discharge in effect on July 1, 2000.

c) DRG Adjustment
The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (c).

1) Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.

2) Qualified Admission. For the purposes of this subsection (c), "Qualified Admission" means a Base Period Claim that was:

A) Assigned by the Department to a DRG that:

i) had been assigned a weighting factor greater than 3.2000; and

ii) for which fewer than 200 Base Period Claims were adjudicated by the Department; and

B) Not a claim:

i) reimbursed under a per diem rate methodology;

ii) for Delivery or Newborn Care; or

iii) for a patient transferred to another facility as described at 89 Ill. Adm. Code 149.25(b)(2).

3) DRG Adjustment Rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:

A) The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and

B) The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and

C) The constant 1.400.

d) Children's Hospital Adjustment
The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (d).

1) Qualifying Hospital. A children's hospital, as defined at 89 Ill. Adm. Code 149.50(c)(3), shall qualify for this payment.

2) Qualified Days. For the purposes of this subsection (d), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding a claim:

A) For Delivery or Newborn Care;

B) Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000; or

C) For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).

3) Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:

A) The sum of Qualified Days from the hospital's Base Period Claims; and

B) For Illinois hospitals with:

i) more than 5,000 Qualified Days, $670.00; or

ii) 5,000 or fewer Qualified Days, $300.00.

C) For out of state hospitals with:

i) more than 1,000 Qualified Days, $670.00; or

ii) 1,000 or fewer Qualified Days, $300.00.

e) Primary Care Adjustment
The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (e).

1) Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident shall qualify for this payment.

2) Qualifying Residents. For the purposes of this subsection (e), "Qualifying Residents" means the number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998, used in the fiscal year 2002 Tertiary Care Adjustment Rate Period.

3) Qualified Admission. For the purposes of this subsection (e), "Qualified Admission" shall mean a Base Period Claim excluding a claim:

A) For hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b) and reimbursed under a per diem rate methodology; and

B) For Delivery or Newborn Care.

4) Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:

A) The number of Qualifying Admissions during the Tertiary Adjustment Base Period;

B) $4,675.00; and

C) The quotient of:

i) the number of Qualifying Residents,

ii) divided by the number of Qualifying Admissions.

f) Long Term Stay Hospital Adjustment
The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (f).

1) Qualifying Hospital. A long term stay hospital, as defined at 89 Ill. Adm. Code 149.50(c)(4), that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.

2) Qualified Days. For the purposes of this subsection (f), "Qualified Day" means a day of care that was provided in a Base Period Claim, excluding claims for hospital inpatient psychiatric services as described at Section 148.40(a) or hospital inpatient physical rehabilitation services as described at Section 148.40(b).

3) Long Term Stay Hospital Adjustment Rates. A Qualifying Hospital will receive payments equal to the product of:

A) The number of Qualified Days from all Base Period Claims; and

B) A constant that:

i) for a hospital that had a CMI that was greater than or equal

to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, $3,000.00~~$300.00~~; or

ii) for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, $5.00.

g) Rehabilitation Hospital Adjustment
The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (g).

1) Qualifying Hospital. A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Section 148.295(b), shall qualify for this payment.

2) Qualified Admission. For the purposes of this subsection (g), "Qualified Admission" shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Section 148.295, for fiscal year 2001.

3) Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:

A) For a hospital that had fewer than 60 Qualified Admissions, $100,000.00.

B) For a hospital that had 60 or more Qualified Admissions, $350,000.00.

h) Tertiary Care Adjustment

1) The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (a) through (g) of this Section multiplied by 0.455.

2) A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.

3) For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Tertiary Care Adjustment Rate period.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.297 Pediatric Outpatient Adjustment Payments

Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for outpatient services occurring on or after July 1, 1998, in accordance with this Section.

a) To qualify for payments under this Section, a hospital must:

1) be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), and

2) have a Pediatric Medicaid Outpatient Percentage greater than 80 percent during the Pediatric Outpatient Adjustment Base Period.

b) Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year for dates of services occurring on or after July-1, 1999:

1) For out-of-state cost reporting hospitals with an MIUR that is less than 75 percent, the product of:

A) the hospital's MIUR plus 1.15, multiplied by

B) the number of Pediatric Adjustable Outpatient Services, multiplied by

C) $169.00.

2) For Illinois hospitals with an MIUR that is less than 75 percent, the product of:

A) the hospital's MIUR plus one, multiplied by

B) the number of Pediatric Adjustable Outpatient Services, multiplied by

C) $169.00.

3) For Illinois hospitals with an MIUR that is greater than or equal to 75 percent, the product of:

A) one and one-half the hospital's MIUR plus one, multiplied by

B) the number of Pediatric Adjustable Outpatient Services, multiplied by

C) $305.00~~$169.00~~.

c) In addition to the reimbursement rates described in subsection (b) of this Section, hospitals that have an MIUR that is greater than or equal to 80 percent shall receive an additional $229,740.00 during the Pediatric Outpatient Adjustment Rate Year.

d) Adjustments under this Section shall be paid at least quarterly.

e) Definitions

1) "Medicaid Inpatient Utilization Rate" or "(MIUR)", as used in this Section, has the same meaning as ascribed in Section 148.120(k)(5), in effect for the rate period October 1, 1996, through September 30, 1997.

2) "Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140(b)(1), during the Pediatric Outpatient Adjustment Base Period. For a hospital, which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28) for children less than 18 years of age, that are billed through the affiliated

general care hospital.

3) "Pediatric Medicaid Outpatient Percentage" means a percentage that results from the quotient of the total Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Period.

4) "Pediatric Outpatient Adjustment Base Period" means all services billed to the Department, excluding procedure code 0080, with State Fiscal Year 1996 dates of service that were adjudicated by the Department on or before March 31, 1997.

5) "Pediatric Outpatient Adjustment Rate Year" means State Fiscal Year 1998 and each State Fiscal Year thereafter.

f) For hospitals qualifying for payments under this Section, adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Pediatric Outpatient Adjustment Rate year.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

Section 148.460 Catastrophic Relief Payments

a) Qualifying Criteria. Catastrophic Relief Payments, as described in this subsection (a), shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under 89 Ill. Adm. Code 149.50(c)(3)(B), that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on the criteria described in this Section.

b) Payments

1) An Illinois hospital qualifying under subsection (a) of this Section that is a general acute care hospital with greater than 3,000 Medicaid admissions and a case mix greater than 70% will receive the greater of:

A) Medicaid admissions multiplied by $2,250; or

B) $8,000,000.

2) An Illinois hospital qualifying under subsection (a) of this Section that received payments under Section 148.456 will receive the greater of:

A) 2% of the annual Outpatient Ambulatory Procedure Listing Increase Payments, as defined in Section 148.456; or

B) $175,000.

3) With the exception of psychiatric hospitals, a hospital qualifying under subsection (a) of this Section will receive the following:

A) $1,750,000 for Illinois hospitals with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.

B) $1,600,000 for Illinois hospitals with greater than or equal to 20 and less than or equal to 50 Title XXI admissions in the Catastrophic Relief Payments base period.

C) $750,000 for Illinois hospitals with greater than 0 and less than 20 Title XXI admissions in the Catastrophic Relief Payments base period.

4) A psychiatric hospital qualifying under subsection (a) of this Section will receive the following:

A) $1,312,500 for an Illinois hospital with more than 50 Title XXI admissions in the Catastrophic Relief Payments base period.

B) $1,200,000 for an Illinois hospital with greater than or equal to 20 and less than or equal to 50 Title XXI admissions in the Catastrophic Relief Payments base period.

C) $562,500 for an Illinois hospital with greater than 0 and less than 20 Title XXI admissions in the Catastrophic Relief Payments base period.

5) Payments under this Section are effective for State fiscal year 2009. Payments are not effective for dates of service on or after July 1, 2009.

c) Definitions

1) "MIUR", for a given hospital, has the meaning ascribed 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 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.

2) "General acute care hospital" is a hospital that does not meet the definition of a hospital ascribed in 89 Ill. Adm. Code 149.50(c).

3) "Title XXI admissions" means recipients of medical assistance through the Illinois State Child Health Plan under Title XXI of the Social Security Act.

4) "Catastrophic Relief Payments base period" means the 12-month period beginning on July 1, 2006 and ending June 30, 2007.

5) "Psychiatric hospital" is a hospital as defined in 89 Ill. Adm. Code 149.50(c)(1).

6) "Case mix index" means, for a given hospital, the quotient resulting from dividing the sum of all the diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, by the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82.

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NOTICE OF PROPOSED AMENDMENTS

7) "Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP (Section 148.295) rate period and contained within the Department's paid claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.

(Source: Added at 33 Ill. Reg. _____, effective _____)

PROPERTY TAX APPEAL BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Practice and Procedure for Appeals Before the Property Tax Appeal Board

2) Code Citation: 86 Ill. Adm. Code 1910

3)

Section Numbers:	Proposed Action:
1910.32	New Section
1910.40	Amended

4) Statutory Authority: 35 ILCS 200/Art. 7 and 16-180 through 16-195

5) A Complete Description of the Subjects and Issues Involved: A new Section has been added for the adoption of filing fees. A Section is being amended to allow the board of review 90-days to submit its "Board of Review Notes on Appeal" and evidence.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

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

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

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

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may comment on this proposed rulemaking by filing comments in writing, within 45 days after the publication of this Notice in the *Illinois Register*, with the Property Tax Appeal Board at its offices in Springfield:

Louis G. Apostol, Executive Director
Illinois Property Tax Appeal Board
Wm. G. Stratton Building
401 South Spring Street, Rm. 402
Springfield, Illinois 62706

217/782-6076
louis.apostol@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: All small businesses owning taxable real property in Illinois, all municipalities with taxing authority and all not for profit corporations that own taxable real estate will be affected by filing fees if they initiate an assessment appeal.

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

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

PROPERTY TAX APPEAL BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 86: REVENUE
CHAPTER II: PROPERTY TAX APPEAL BOARD

PART 1910
PRACTICE AND PROCEDURE FOR APPEALS
BEFORE THE PROPERTY TAX APPEAL BOARD

Section

PROPERTY TAX APPEAL BOARD

NOTICE OF PROPOSED AMENDMENTS

1910.88 Use of Facsimile Machines
1910.90 Procedural Hearing Rules
1910.91 Business Records (Repealed)
1910.92 Rules of Pleading, Practice and Evidence
1910.93 Request for Witnesses
1910.94 Inspection of Subject Property − Effect of Denial by Taxpayer or Property Owner
1910.95 Service of Documents in Certain Cases
1910.96 Evidence Depositions
1910.98 Transcription of Hearings − Official Record
1910.99 Adoption of Evidence
1910.100 Severability

AUTHORITY: Implementing and authorized by Article 7 and Sections 16-180 through 16-195 of the Property Tax Code [35 ILCS 200/Art. 7 and 16-180 through 16-195].

SOURCE: Adopted at 4 Ill. Reg. 23, p. 106, effective May 27, 1980; codified at 8 Ill. Reg. 19475; amended at 13 Ill. Reg. 16454, effective January 1, 1990; amended at 21 Ill. Reg. 3706, effective March 6, 1997; amended at 21 Ill. Reg. 11949, effective August 13, 1997; amended at 21 Ill. Reg. 14551, effective October 27, 1997; amended at 22 Ill. Reg. 957, effective December 19, 1997; amended at 22 Ill. Reg. 16533, effective September 2, 1998; amended at 24 Ill. Reg. 1233, effective January 5, 2000; amended at 29 Ill. Reg. 13574, effective August 19, 2005; amended at 29 Ill. Reg. 21046, effective December 16, 2005; amended at 30 Ill. Reg. 1419, effective January 20, 2006; amended at 30 Ill. Reg. 2640, effective February 15, 2006; amended at 30 Ill. Reg. 7965, effective April 14, 2006; amended at 30 Ill. Reg. 10103, effective May 16, 2006; expedited correction at 30 Ill. Reg. 14633, effective May 16, 2006; amended at 30 Ill. Reg. 12280, effective June 30, 2006; amended at 30 Ill. Reg. 14148, effective August 11, 2006; amended at 30 Ill. Reg. 16311, effective September 29, 2006; amended at 31 Ill. Reg. 16222, effective November 26, 2007; amended at 32 Ill. Reg. 16864, effective October 1, 2008; amended at 33 Ill. Reg. _____, effective _____.

Section 1910.32 Filing Fees

a) This Section contains the Board's general filing fee requirements. Additional requirements exist for petitions elsewhere in this Part. Every petition for appeal filed July 1, 2009 and thereafter shall be accompanied by payment of a filing fee. The payment must be made in accordance with the following schedule, based on the type of property that is the subject of the appeal:

PROPERTY TAX APPEAL BOARD

NOTICE OF PROPOSED AMENDMENTS

	<$100,000 of assessed value in dispute	$100,000 to $299,999 of assessed value in dispute	$300,000 or more of assessed value in dispute
Residential	$25	$75	$150
Farm	$25	$75	$150
Commercial	$250	$350	$450
Industrial	$250	$350	$450

b) The fee payment shall be made by certified bank check, cashier's check, personal check, money order, or by electronic means made payable to the "Property Tax Appeal Board". The payment shall not be made in cash.

c) In cases of a single petition for appeal consisting of multiple parcels constituting a single subject property, the filing fee for the petition for appeal shall be based upon the sum of the assessment reductions requested for the multiple parcels. Multiple appeals involving the same property may be consolidated for purposes of hearing pursuant to Section 1910.78; however, multiple individual parcels that do not constitute a single subject property may not be filed on a single petition for appeal in order to compute the required filing fees.

d) For purposes of this Section, "assessed value in dispute" means the difference between the assessed value on the final written notice of the decision of the board of review and the appellant's requested assessed value/relief as stated on the petition for appeal form. If the petitioner is unable to calculate the requested assessed value/relief amount at the time of filing of the petition for appeal, the minimum filing fee applicable to the type of property that is the subject of the appeal must be submitted in accordance with subsection (a) of this Section; an additional fee amount, if any, must be supplied in accordance with a Board order establishing a deadline for submission of written or documentary evidence pursuant to Section 1910.30(g).

e) If the filing fee does not accompany the petition for appeal or has been miscalculated, the necessary fee must be received by the Board within 30 days after the issuance of notice of an incomplete petition for appeal pursuant to Section 1910.30(k). If the necessary fee is not subsequently filed within the allotted time period, the petition for appeal shall be considered incomplete and the petition for appeal shall be dismissed.

f) The filing fee is nonrefundable, except that, in cases in which there is a duplicate filing on the same property in the same assessment year, the second filing fee will be returned to the submitting party.

g) No action will be taken on a petition for appeal until any fee due is remitted in accordance with this Section. The Board will dismiss a petition for appeal when the appellant has failed to comply with this Section or payment is otherwise rejected.

(Source: Added at 33 Ill. Reg. _____, effective _____)

Section 1910.40 Board of Review Response to Petition Application

a) Upon receipt of the completed petition from the contesting party, the Clerk of the Property Tax Appeal Board shall notify the board of review of the filing of the appeal. Upon notification of the filing of the appeal, the board of review shall submit its completed Board of Review Notes on Appeal disclosing the final assessment of the subject property. The Board of Review Notes on Appeal shall also reflect the application of a local township multiplier where applicable. The board of review shall also submit a copy of the property record card of the subject property. The property record card should contain, ifwhere possible, a schematic drawing of all structural improvements to the land, a completed cost analysis, and an indication of the basis of the land value. The Board of Review Notes on Appeal and all written and documentary evidence supporting the board of review's position must be submitted to the Property Tax Appeal Board within 9030 days after the date of theand/or postmark of the notice of the filing of an appeal unless the board of review objects to the jurisdiction of the Property Tax Appeal Board over the assessment appeal. In every case in whichwhere a change in assessed valuation of less than $100,000 is sought, all written and documentary evidence must be submitted in duplicate. In every case in whichwhere a change in assessed valuation of $100,000 or more is sought, all written and documentary evidence must be submitted in triplicate.

b) If the board of review objects to the Board's jurisdiction, it must submit a written request for dismissal of the petition prior to the submission of the Board of Review Notes on Appeal and accompanying documentation. The request for dismissal must set forth the basis of the board of review's objections to the Property Tax Appeal Board's jurisdiction over the appeal. In such cases, the

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Property Tax Appeal Board shall transmit a copy of the request for dismissal to the contesting party and secure a written response to the request for dismissal from the contesting party within 30 days after the postmark date of the notice of the filing of the motion to dismiss. A copy of the response shall be transmitted to the board of review. Upon receipt of the request for dismissal and the response, the Property Tax Appeal Board shall issue a decision determining if it has jurisdiction in the matter.

c) If the board of review objects to the Board's jurisdiction and the Property Tax Appeal Board subsequently determines that it has jurisdiction over the parties and the subject matter of the appeal, the board of review shall submit its Board of Review Notes on Appeal, the subject's property record card and all written and documentary evidence within 30 days after the Board's decision determining jurisdiction.

d) If the board of review is unable to submit the additional written or documentary evidence with the Notes on Appeal, it must submit a letter requesting an extension of time with the Board of Review Notes on Appeal. Upon receipt of the~~such a~~ request, the Board shall grant a 30 day extension of time. The Board shall grant additional or longer extensions for good cause shown. Good cause may include, but is not limited to, the inability to submit evidence for a cause beyond the control of the board of review, such as the pendency of court action affecting the assessment of the property or the death or serious illness of a valuation witness. Without a written request for an extension, no evidence will be accepted after the Board of Review Notes on Appeal is filed.

e) The Clerk shall cause the board of review's evidence to become a part of the~~such~~ appeal proceeding and record~~,~~ and shall send a copy of the evidence~~same~~ to the contesting party or his or her attorney.

f) Pursuant to Section 16-180 of the Property Tax Code, in every case in which~~where~~ a change in assessed valuation of $100,000 or more is sought, the board of review shall, within 30 days after the receipt of the notice of the filing of an appeal with the Board, serve a copy of the petition on all taxing districts as shown on the last available tax bill. The board of review shall also serve a certificate of service on the Property Tax Appeal Board, within 30 days after the receipt of the notice of the filing of an appeal with the Board, affirming that all taxing districts have been notified of the appeal. The certificate of service shall be signed by a member of the board of review or the clerk of the board of review.

PROPERTY TAX APPEAL BOARD

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(Source: Amended at 33 Ill. Reg. _____, effective _____)

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Contract Procurement

2) Code Citation: 44 Ill. Adm. Code 660

3)

Section Numbers:	Proposed Action:
660.100	Amend
660.380	Amend

4) Statutory Authority: Implementing, and authorized by Section 5-25 of, the Illinois Procurement Code [30 ILCS 500]

5) A Complete Description of the Subjects and Issues Involved: The changes to the small purchase threshold amounts made throughout Section 660.100 implement and apply the recommendations of the Illinois Procurement Policy Board. The Department also added a provision at Section 660.100(a) to clarify that the Department of Central Management Services determines, in accordance with 44 Ill. Adm. Code 1.2020, whether a contract for supplies or services is under or at the threshold limit.

The change made at Section 660.100(c)(1) is consistent with the threshold change made at Section 660.100(b).

The deleted language in Section 660.100(c)(3), is consistent with the change made to Section 660.100(c)(1). A determination of germaneness is no longer necessary for change orders that do not exceed $70,000.

At Section 660.100(c)(5), the Department is adding provisions to clarify that change orders in excess of $70,000 are effective when the 30 day time period provided in Section 5-30 of the Illinois Procurement Code (the Code) has expired or when the Procurement Policy Board has granted a waiver pursuant to Section 5-30 of the Code.

Finally, at Section 660.380, the Department is clarifying that some notices of contracts are required to be published in the Illinois Procurement Bulletin.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

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

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9) Does this rulemaking contain incorporations by reference? No

10) Are there any proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: Upon adoption of this rulemaking, units of local government will do less paperwork and less monitoring concerning compliance with Departmental policies.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Any interested party may submit written comments or arguments concerning this proposed rulemaking. Written submissions shall be filed with:

Mr. Michael F. Renner, Acting Engineer of Construction
Illinois Department of Transportation
Bureau of Construction
2300 S. Dirksen Parkway, Room 322
Springfield, Illinois 62764

217/782-6667

JCAR requests, comments and concerns regarding this rulemaking should be addressed to:

Ms. Christine Caronna-Beard, Rules Manager
Illinois Department of Transportation
Office of Chief Counsel
2300 South Dirksen Parkway, Room 317
Springfield, Illinois 62764

217/524-3838

Comments received within 45 days after the date of publication of this *Illinois Register* will be considered. Comments received after that time will be considered, time permitting.

13) Initial Regulatory Flexibility Analysis:

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A) Types of small businesses, small municipalities and not for profit corporations affected: When procuring supplies or services, this rulemaking will have a positive impact on small businesses. DOT will be able to award contracts to small businesses without going through invitation to bid procedures (under the $50,000 threshold). Small businesses will not have to complete bid documents, but will provide a quote that DOT will compare to 2 or 3 other quotes and award the contract to the best priced vendor. As all purchases under $50,000 currently must be set aside for small businesses, DOT will contact the small businesses for quotes if the small businesses are available for the supply or service needed.

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

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

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NOTICE OF PROPOSED AMENDMENTS

TITLE 44: GOVERNMENT CONTRACTS, PROCUREMENT AND PROPERTY MANAGEMENT
SUBTITLE B: SUPPLEMENTAL PROCUREMENT RULES
CHAPTER IX: DEPARTMENT OF TRANSPORTATION

PART 660
CONTRACT PROCUREMENT

SUBPART A: GENERAL

SUBPART B: PUBLICATION OF PROCUREMENT INFORMATION

SUBPART C: METHODS OF PROCUREMENT

SUBPART D: COMPETITIVE SEALED BID PROCEDURES

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SUBPART E: COMPETITIVE SEALED PROPOSAL PROCEDURES

SUBPART F: PROTESTS

SUBPART G: SPECIFICATIONS

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SUBPART H: SUSPENSION OF CONTRACTORS

SUBPART I: MISCELLANEOUS

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660.740 Written Determinations
660.750 Severability

AUTHORITY: Implementing, and authorized by Section 5-25 of, the Illinois Procurement Code [30 ILCS 500].

SOURCE: Adopted by emergency rulemaking at 22 Ill. Reg. 11602, effective July 1, 1998, for a maximum of 150 days; adopted at 22 Ill. Reg. 21060, effective November 25, 1998; emergency amendment at 29 Ill. Reg. 7832, effective May 12, 2005, for a maximum of 150 days; emergency expired October 8, 2005; amended at 29 Ill. Reg. 18147, effective October 19, 2005; amended at 33 Ill. Reg. _____, effective _____.

SUBPART C: METHODS OF PROCUREMENT

Section 660.100 Small Contracts

a) Individual contracts for supplies or services from any one source that do not exceed $50,000~~$10,000~~ may be made without notice, competition or use of any other method of procurement prescribed in the Code or this Part. (See Section 20-20(a) of the Code.) Contracts for professional and artistic services that do not exceed $20,000 for a nonrenewable term of not more than one year will be procured in accordance with this Section. Determination of whether a contract for supplies or services is under or at the limit will be made in accordance with the Department of Central Management Services' rules governing small purchases. (See 44 Ill. Adm. Code 1.2020.)

b) Construction contracts, construction supply contracts, construction-related service contracts and change orders ~~made thereto~~ that do not exceed $70,000~~$30,000~~ may be procured without notice, competition or use of any other method of procurement prescribed in the Code or this Part. (See Section 20-20 of the Code.)

c) Section 30-35 of the Code provides that a construction contract change order may cause the obligation or expenditure of funds in excess of the original contract price provided that the subject of the change order is germane to the original contract. Section 30-35 of the Code further establishes the manner in which the amount of additional expenditure or obligation will be determined and authorized by the Department. The Department will approve construction contract change orders authorizing the obligation or expenditure of additional funds without supplemental procurement procedures, in accordance with the following

requirements and thresholds.

1) A construction contract change order that is germane and that causes the obligation or expenditure in excess of the amounts in Section 30-35(b) of the Code ~~or of more than $30,000 in excess of the contract price, whichever is less,~~ will not be authorized without supplemental procurement procedures unless the scope of the change order is approved as provided in Section 30-35 of the Code.

2) Determination of germaneness and the amount of additional expenditure or obligation thresholds will be determined in accordance with this Part and Section 30-35 of the Code.

3) Prior written approval or disapproval will be made by the Department ~~in accordance with the threshold amounts established in Section 30-35 of the Code, and~~ in all cases if the contemplated construction contract change order will cause an expenditure or obligation of funds of more than $70,000~~$30,000~~ in excess of the contract price even though the threshold levels provided in Section 30-35 of the Code do not require such action. The written approval will state the reasons for the additional obligation or expenditure and the basis for the germaneness determination.

4) For purposes of determining the scope of the change order and the value thereof that is subject to the requirements of this Section, the Department will consider the total net value of all added and deducted work functions related to the object of the change order and the work of the contract to be affected.

5) Notice of approved construction contract change orders in excess of $70,000~~$30,000~~ will be published in the Transportation Bulletin. Change orders of $70,000 or less shall be effective when approved by the Department. Change orders in excess of $70,000 shall be effective when the 30 day period provided in Section 5-30 of the Code has expired, unless the Procurement Policy Board has granted a waiver as provided in Section 5-30 of the Code.

d) Estimated needs shall not be divided in any manner to avoid the use of an established method of procurement. (See Section 20-20(a) of the Code.)

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(Source: Amended at 33 Ill. Reg. _____, effective _____)

SUBPART E: COMPETITIVE SEALED PROPOSAL PROCEDURES

Section 660.380 Publication of Contracts

Notice of contracts entered into by the Department pursuant to this Subpart E will be published in the appropriate version of the Transportation Bulletin or the Illinois Procurement Bulletin.

(Source: Amended at 33 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF REFUSAL TO MEET THE OBJECTION OF
THE JOINT COMMITTEE ON ADMINISTRATIVE RULES

1) Heading of the Part: Consumer Installment Loan Act

2) Code Citation: 38 Ill. Adm. Code 110

3)

Section Numbers:	Action:
110.300	Refusal
110.310	Refusal
110.320	Refusal
110.330	Refusal
110.340	Refusal
110.350	Refusal
110.360	Refusal
110.370	Refusal
110.380	Refusal
110.390	Refusal
110.400	Refusal
110.410	Refusal
110.420	Refusal
110.430	Refusal

4) Date Notice of Proposed Amendments Published in the Register: 32 Ill. Reg. 13127; August 8, 2008

5) Date JCAR Statement of Objection Published in the Register: January 30, 2009; 33 Ill. Reg. 1822

6) Summary of Action Taken by Agency: At its 1/13/09 meeting, JCAR objected to this rulemaking stating that the Department lacked statutory authority for the rulemaking and that the rulemaking "could place an undue economic burden on lenders". With respect to the Department's statutory authority, in 2000, the legislature passed a law with the specific intent of granting the Department rulemaking authority to protect short-term borrowers. *See South 51 Development Corp. v. Vega*, 335 Ill. App. 3d 542, 554, 781 N.E.2d 528, 539 (1st Dist. 2002), *appeal dismissed*, 211 Ill. 2d 189, 809 N.E.2d 122 (2004). The law provided that the Department "may promulgate rules in connection with the activities of licensees that are necessary and appropriate for the protection of consumers in this state". 205 ILCS 670/22. The Department adopted the current title loan rules on August 1, 2001. Certain licensees challenged the rules, and the appellate court upheld the trial court's decision in favor of the Department. The court found that the rules "are consistent

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF REFUSAL TO MEET THE OBJECTION OF
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with and do not transcend the scope of [CILA's] statutory scheme". *South 51*, 335 Ill. App. 3d at 557 781 N.E.2d at 541. These amendments further clarify the existing rules and provide additional protection for consumers in this state.

With respect to a possible burden on lenders, the Department, as specifically directed by JCAR, negotiated with the interested stakeholders on this rulemaking, and a significant portion of the industry agreed to support these rules.

IDFPR will adopt the amendments as submitted to JCAR with Second Notice changes.

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PUBLIC INFORMATION

LISTING OF DERIVED WATER QUALITY CRITERIA

Pursuant to 35 Ill. Adm. Code 302.595 and 302.669, the following water quality criteria have been derived as listed. This listing updates revisions to existing criteria for the period October 1, 2008 through December 31, 2008.

A cumulative listing of criteria as of July 31, 1993 was published in 17 Ill. Reg. 18904, October 29, 1993. Listings of waterbodies for which water quality criteria were used during subsequent three month periods were published in 18 Ill. Reg. 318, January 7, 1994; 18 Ill. Reg. 4457, March 18, 1994; 18 Ill. Reg. 8734, June 10, 1994; 18 Ill. Reg. 14166, September 9, 1994; 18 Ill. Reg. 17770, December 9, 1994; 19 Ill. Reg. 3563, March 17, 1995; 19 Ill. Reg. 7270, May 26, 1995: 19 Ill. Reg. 12527, September 1, 1995; 20 Ill. Reg. 649, January 5, 1996; 20 Ill. Reg. 4829, March 22, 1996; 20 Ill. Reg. 7549, May 30, 1996; 20 Ill. Reg. 12278, September 6, 1996; 20 Ill. Reg. 15619, December 6, 1996; 21 Ill. Reg. 3761, March 21, 1997; 21 Ill. Reg. 7554, June 13, 1997; 21 Ill. Reg. 12695, September 12, 1997; 21 Ill. Reg. 16193, December 12, 1997; 22 Ill. Reg. 5131, March 13, 1998; 22 Ill. Reg. 10689, June 12, 1998; 22 Ill. Reg. 16376, September 11, 1998; 22 Ill. Reg. 22423, December 28, 1998; 23 Ill. Reg. 3102, March 12, 1999; 23 Ill. Reg. 6979, June 11, 1999; 23 Ill. Reg. 11774, September 24, 1999; 23 Ill. Reg. 14772, December 27, 1999; 24 Ill. Reg. 4251, March 17, 2000; 24 Ill. Reg. 8146, June 9, 2000; 24 Ill. Reg. 14428, September 29, 2000; 25 Ill. Reg. 270, January 5, 2001; 25 Ill. Reg. 4049, March 16, 2001; 25 Ill. Reg. 7367, June 8, 2001; 25 Ill. Reg. 12186, September 21, 2001; 25 Ill. Reg. 16175, December 14, 2001; 26 Ill. Reg. 4974, March 29, 2002; 26 Ill. Reg. 13370, September 6, 2002; 27 Ill. Reg. 1736, January 31, 2003; 27 Ill. Reg. 7350, April 18, 2003; 27 Ill. Reg. 17128, November 7, 2003; 28 Ill. Reg. 5038, March 19, 2004; 28 Ill. Reg. 8363, June 11, 2004; 28 Ill. Reg. 12943, September 17, 2004; 29 Ill. Reg. 1449, January 21, 2005; 29 Ill. Reg. 7239, May 20, 2005; 29 Ill. Reg. 12672, August 12, 2005; 29 Ill. Reg. 18963, November 18, 2005; 30 Ill. Reg. 5458, March 17, 2006, 30 Ill. Reg. 9195, May 12, 2006 and 30 Ill. Reg. 14377, September 1, 2006; 31 Ill Reg. 4941, March 23, 2007; 31 Ill. Reg. 7477, May 25, 2007; 31 Ill. Reg. 13233, September 14, 2007; 31 Ill. Reg. 15875, November 26, 2007; 32 Ill. Reg. 4271, March 21, 2008; 32 Ill. Reg. 8454, June 6, 2008; 32 Ill. Reg. 13595, August 15, 2008 and 32 Ill. Reg. 19961, December 19, 2008.

Aquatic life and human health criteria for General Use (35 Ill. Adm. Code 303.201) and Lake Michigan Basin (35 Ill. Adm. Code 303.443) waters are listed below. General Use human health criteria are derived for protection of primary contact waters, criteria derived for waters not supportive of primary contact recreation are specified, where applicable. General Use and Lake Michigan Basin waters used as Public and Food Processing Water Supplies (35 Ill. Adm. Code 303.202) are subject to more stringent human health criteria as specified in their respective derivation procedures (35 Ill. Adm. Code 302.648 and 302.657 and 35 Ill. Adm. Code 302.585

and 302.590, respectively). Newly derived criteria or criteria used in NPDES permitting this quarter are highlighted in bold print.

General Use Criteria

Chemical: Acenaphthene CAS #83-32-9 Acute criterion: 120 ug/l Chronic criterion: 62 ug/l Date criteria derived: November 14, 1991; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Acenaphthylene CAS # 208-96-8 Acute criterion: 190 ug/L Chronic criterion: 15 ug/L Date criteria derived: March 1, 1998 Applicable waterbodies: Not used during this period.
Chemical: Acetochlor CAS #34256-82-1 Acute criterion: 150 ug/l Chronic criterion: 12 ug/l Date criteria derived: September 26, 2007 Applicable waterbodies: Not used during this period.
Chemical: Acetone CAS #67-64-1 Acute criterion: 1,500 mg/l Chronic criterion: 120 mg/l Date criteria derived: May 25, 1993 Applicable waterbodies: Not used during this period.
Chemical: Acetonitrile CAS #75-05-8 Acute criterion: 380 mg/l Chronic criterion: 30 mg/l Human health criterion (HTC): non-primary contact, 20 mg/L Date criteria derived: December 7, 1993; revised January 23, 2007 Applicable waterbodies: Not used during this period.
Chemical: Acrolein CAS #107-02-8 Acute criterion: 2.7 µg/l Chronic criterion: 0.22 µg/l Date criteria calculated: February 1999; reviewed January 2008 Applicable waterbodies: Not used during this period.
Chemical: Acrylonitrile CAS #107-13-4 Acute criterion: 910 ug/l Chronic criterion: 73 ug/l Human health criterion (HNC): 0.21 ug/l Date criteria derived: November 13, 1991 Applicable waterbodies: Not used during this period.

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PUBLIC INFORMATION

LISTING OF DERIVED WATER QUALITY CRITERIA

Chemical: Anthracene CAS #120-12-7 Acute criterion: 0.66 ug/L Chronic Criterion: 0.53 ug/L Human health criterion (HTC): 35 mg/l Date criteria derived: August 18, 1993, revised May 30, 2007 Applicable waterbodies: Not used during this period.
Chemical: Antimony CAS #7440-36-0 Acute criterion: 1,200 ug/L Chronic Criterion: 320 ug/L Human health criterion (HTC): 12,000 ug/l Non-primary contact: 1,200 ug/l Public and food processing water supply: 6 ug/l Date criteria derived: September 29, 2008 Applicable waterbodies: Not used during this period.
Chemical: Atrazine CAS #1912-24-9 Acute criterion: 82 ug/l Chronic criterion: 9.0 ug/L Date criteria derived: May 2, 2005 Applicable waterbodies: Not used during this period.
Chemical: Benzo(a)anthracene CAS #56-55-3 Human health criterion (HNC): 0.16 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Benzo(a)pyrene CAS #50-32-8 Human health criterion (HNC): 0.016 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Benzo(b)fluoranthene CAS # 205-99-2 Human health criterion (HNC): 0.16 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Benzo(k)fluoranthene CAS #207-08-9 Human health criterion (HNC): 1.6 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Carbon tetrachloride CAS #56-23-5 Acute criterion: 3,500 ug/l Chronic criterion: 280 ug/l Human health criterion (HNC): 1.4 ug/l Date criteria derived: June 18, 1993

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.
Chemical: Chlorobenzene CAS #108-90-7 Acute criterion: 990 ug/l Chronic criterion: 79 ug/l Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.
Chemical: Chloroethane CAS #75-00-3 Acute criterion: 13 mg/l Chronic criterion: 1 mg/l Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.
Chemical: Chloromethane CAS #74-87-3 Acute criterion: 16 mg/l Chronic criterion: 1.3 mg/l Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.
Chemical: Chloroform CAS #67-66-3 Acute criterion: 1,900 ug/l Chronic criterion: 150 ug/l Human health criterion (HNC): 130 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.
Chemical: Chrysene CAS #218-01-9 Human health criterion (HNC): 16 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Dibenz(a,h)anthracene CAS #53-70-3 Human health criterion (HNC): 0.016 ug/l Date criteria derived : February, 1999, reviewed June 2007 Applicable waterbodies: Not used during this period.
Chemical: 1,2-dichlorobenzene CAS #95-50-1 Acute criterion: 210 ug/l Chronic criterion: 17 ug/l Date criteria derived: December 1, 1993 Applicable waterbodies: Not used during this period.
Chemical: 1,3-dichlorobenzene CAS #541-73-1 Acute criterion: 500 ug/l Chronic criterion: 200 ug/l Date criteria derived: July 31, 1991 Applicable waterbodies: Not used during this period.
Chemical: 1,1-dichloroethane CAS #75-34-3 Acute criterion: 20 mg/l Chronic criterion: 2 mg/l

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: July 31, 1991 Applicable waterbodies: Not used during this period.
Chemical: 1,2-dichloroethane CAS #107-06-2 Acute criterion: 25 mg/l Chronic criterion: 4.5 mg/l Human health criterion (HNC): 23 ug/l Date criteria derived: March 19, 1992 Applicable waterbodies: Not used during this period.
Chemical: 1,1-dichloroethylene CAS #75-35-4 Acute criterion: 3,000 ug/l Chronic criterion: 240 ug/l Human health criterion (HNC): 0.95 ug/l Date criteria derived: March 20, 1992 Applicable waterbodies: Not used during this period.
Chemical: 1,2-dichloroethylene CAS #540-59-0 **Acute criterion: 14 mg/l Chronic criterion: 1.1 mg/l** **Date criteria derived: November 18, 2008** **Applicable waterbodies: Not used during this period.**
Chemical: 2,4-dichlorophenol CAS #120-83-2 Acute criterion: 630 ug/l Chronic criterion: 83 ug/l Date criteria derived: November 14, 1991 Applicable waterbodies: Not used during this period.
Chemical: 1,2-dichloropropane CAS #78-87-5 Acute criterion: 4,800 ug/l Chronic criterion: 380 ug/l Date criteria derived: December 7, 1993 Applicable waterbodies: Not used during this period.
Chemical: 1,3-dichloropropylene CAS #542-75-6 Acute criterion: 99 ug/l Chronic criterion: 7.9 ug/l Date criteria derived: November 13, 1991 Applicable waterbodies: Not used during this period.
Chemical: 2,4-dimethyl phenol CAS #105-67-9 Acute criterion: 740 ug/l Chronic criterion: 220 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.
Chemical: 4,6-dinitro-o-cresol = 2-methyl-4,6-dinitrophenol CAS #534-52-1 Acute criterion: 29 ug/l Chronic criterion: 2.3 ug/l Date criteria derived: November 14, 1991 Applicable waterbodies: Not used during this period.

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Chemical: 2,4-dinitrophenol CAS #51-28-5 Acute criterion: 85 ug/l Chronic criterion: 4.1 ug/l Date criteria derived: December 1, 1993 Applicable waterbodies: Not used during this period.
Chemical: 2,6-dinitrotoluene CAS #606-20-2 Acute criterion: 1,900 ug/l Chronic criterion: 150 ug/l Date criteria derived: February 14, 1992 Applicable waterbodies: Not used during this period.
Chemical: Diquat CAS #85-00-7 Acute criterion: 990 ug/l Chronic criterion: 80 ug/l Date criteria derived: January 30, 1996 Applicable waterbodies: Not used during this period.
Chemical: Ethyl mercaptan (ethanethiol) CAS #75-08-1 Acute criterion: 17 ug/l Chronic criterion: 2 ug/l Date criteria derived: April 8, 2002 Applicable waterbodies: Not used during this period.
Chemical: Fluoranthene CAS #206-44-0 Acute criterion: 4.3 ug/L Chronic Criterion: 1.8 ug/L Human health criterion (HTC): 120 ug/l Date criteria derived: August 10, 1993; revised June 6, 2007 (Acute/Chronic) Applicable waterbodies: Not used during this period.
Chemical: Fluorene CAS #86-73-7 Acute criterion: 59 ug/L Chronic Criterion: 16 ug/L Date criteria derived: June 6, 2007 Applicable waterbodies: Not used during this period.
Chemical: Formaldehyde CAS #50-00-0 Acute criterion: 4.9 mg/l Chronic criterion: 0.39 mg/l Date criteria derived: January 19, 1993 Applicable waterbodies: Not used during this period.
Chemical: Hexachlorobenzene CAS #118-74-1 Human health criterion (HNC): 0.00025 ug/l Date criteria derived: November 15, 1991 Applicable waterbodies: Not used during this period.
Chemical: Hexachlorobutadiene CAS #87-68-3 Acute criterion: 35 ug/l Chronic criterion: 2.8 ug/l Date criteria derived: March 23, 1992

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PUBLIC INFORMATION

LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.
Chemical: Hexachloroethane CAS #67-72-1 Acute criterion: 380 ug/l Chronic criterion: 31 ug/l Human health criterion (HNC): 2.9 ug/l Date criteria derived: November 15, 1991 Applicable waterbodies: Not used during this period.
Chemical: n-Hexane CAS #110-54-3 Acute criterion: 250 ug/l Chronic criterion: 20 ug/l Date criteria derived: April 8, 2002 Applicable waterbodies: Not used during this period.
Chemical: Indeno(1,2,3-cd)pyrene CAS #193-39-5 Human health criterion (HNC): 0.16 ug/l Date criteria calculated: February, 1992, reviewed June 2007 Applicable waterbodies: Not used during this period.
Chemical: Isobutyl alcohol = 2-methyl-1-propanol CAS #78-83-1 Acute criterion: 430 mg/l Chronic criterion: 35 mg/l Date criteria derived: December 1, 1993 Applicable waterbodies: Not used during this period.
Chemical: Methylene chloride CAS #75-09-2 **Acute criterion: 17 mg/l Chronic criterion: 1.4 mg/l** **Human health criterion (HNC): 330 ug/l** **Non-primary contact: 490 ug/l** **Public and food processing water supply: 4.6 ug/l** **Date criteria derived: January 21, 1992; revised November 25, 2008** **Applicable waterbodies: Not used during this period.**
Chemical: Methylethylketone CAS #78-93-3 Acute criterion: 320 mg/l Chronic criterion: 26 mg/l Date criteria derived: July 1, 1992 Applicable waterbodies: Not used during this period.
Chemical: 4-methyl-2-pentanone CAS #108-10-1 Acute criterion: 46 mg/l Chronic criterion: 1.4 mg/l Date criteria derived: January 13, 1992 Applicable waterbodies: Not used during this period.
Chemical: 2-methyl phenol CAS #95-48-7 Acute criterion: 4.7 mg/l Chronic criterion: 0.37 mg/l Date criteria derived: November 8, 1993

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.
Chemical: 4-methyl phenol CAS #106-44-5 Acute criterion: 670 ug/l Chronic criterion: 120 ug/l Date criteria derived: January 13, 1992 Applicable waterbodies: Not used during this period.
Chemical: Methyl tert-butyl ether (MTBE) CAS #134-04-4 Acute criterion: 67 mg/l Chronic criterion: 5.4 mg/l Date criteria derived: September 18, 1997 Applicable waterbodies: Not used during this period.
Chemical: Metolachlor CAS #51218-45-2 Acute criterion: 380 ug/l Chronic criterion: 30.4 ug/l Date criteria derived: February 25, 1992; revised October 1, 2007 Applicable waterbodies: Not used during this period.
Chemical: Naphthalene CAS #91-20-3 Acute criterion: 510 ug/l Chronic criterion: 68 ug/l Date criteria derived: November 7, 1991; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: 4-nitroaniline CAS #100-01-6 Acute criterion: 1.5 mg/l Chronic criterion: 0.12 mg/l Date criteria derived: May 5, 1996 Applicable waterbodies: Not used during this period.
Chemical: Nitrobenzene CAS #98-95-3 Acute criterion: 15 mg/l Chronic criterion: 8.0 mg/l Human health criterion (HTC): 0.52 mg/l Date criteria derived: February 14, 1992; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Pentachlorophenol Acute criterion: 20 ug/l Chronic criterion: 13 ug/l Date criteria derived: national criterion at pH of 7.8, September 1986 Applicable waterbodies: Not used during this period.
Chemical: Phenanthrene CAS #85-01-8 Acute criterion: 46 ug/l Chronic criterion: 3.7 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.
Chemical: Propylene CAS #115-07-1 Acute criterion: 4.0 mg/l Chronic criterion 0.40 mg/l

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LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: April 8, 2002 Applicable waterbodies: Not used during this period.
Chemical: Pyrene CAS #120-00-0 Human health criterion (HTC): 3.5 mg/l Date criteria derived: December 22, 1992 Applicable waterbodies: Not used during this period.
Chemical: Tetrachloroethylene CAS #127-18-4 Acute criterion: 1,200 ug/l Chronic criterion: 150 ug/l Date criteria derived: March 23, 1992 Applicable waterbodies: Not used during this period.
Chemical: Tetrahydrofuran CAS #109-99-9 Acute criterion: 220 mg/l Chronic criterion: 17 mg/l Date criteria derived: March 16, 1992 Applicable waterbodies: Not used during this period.
Chemical: 1,2,4-trichlorobenzene CAS #120-82-1 Acute criterion: 370 ug/l Chronic criterion: 72 ug/l Date criteria derived: December 14, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Thallium CAS #7440-28-0 **Acute criterion: 86 ug/l Chronic criterion: 11 ug/l** **Human health criterion (HTC): 3.0 ug/l** **Non-primary contact: 3.0 ug/l** **Public and food processing water supply: 1.2 ug/l** **Date criteria derived: October 22, 2007; revised November 18, 2008** **Applicable waterbodies: Not used during this period.**
Chemical: 1,1,1-trichloroethane CAS #71-55-6 Acute criterion: 4,900 ug/l Chronic criterion: 390 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.
Chemical: 1,1,2-trichloroethane CAS #79-00-5 Acute criterion: 19 mg/l Chronic criterion: 4.4 mg/l Human health criterion (HNC): 12 ug/l Date criteria derived: December 13, 1993; revised February 1999 Applicable waterbodies: Not used during this period.
Chemical: Trichloroethylene CAS #79-01-6 **Acute criterion: 12,000 ug/l Chronic criterion: 940 ug/l**

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Human health criterion (HNC): 25 ug/l
Non-primary contact: 26 ug/l
Public and food processing water supply: 2.5 ug/l
Date criteria derived: October 23, 1992; revised November 18, 2008
Applicable waterbodies: Not used during this period.

Chemical: Vinyl chloride **CAS #75-01-4**
Acute criterion: 22 mg/l **Chronic criterion: 1.7 mg/l**
Human health criterion (HNC): 1.5 ug/l
Non-primary contact: 2 ug/l
Public and food processing water supply: 0.025 ug/l
Date criteria derived: October 23, 1992; revised January 23, 2007; revised November 17, 2008
Applicable waterbodies: Not used during this period.

Lake Michigan Basin Criteria

Chemical: Antimony CAS #7440-36-0
Aquatic Life Criteria:
Acute criterion: 470 ug/l Chronic criterion: 120 ug/l
Date criteria derived: September 29, 2008
Applicable waterbodies: Not used during this period.

Chemical: Bis(2-ethylhexyl)phthalate CAS #117-81-7
Aquatic Life Criteria:
Acute criterion: 76 ug/l Chronic criterion: 17 ug/l
Human Health Non-threshold Criteria:
Public and food processing water supply: 2.8 ug/l
Non-drinking water: 3.2 ug/l
Date criteria derived: June 20, 2006
Applicable waterbodies: Not used during this period.

Chemical: 1,2-dichloroethylene **CAS #540-59-0**
Aquatic Life Criteria:
Acute criterion: 8.8 mg/l **Chronic criterion: 0.98 mg/l**
Date criteria derived: November 18, 2008

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.

Chemical: Methylene Chloride CAS #75-09-2
Aquatic Life Criteria:
Acute criterion: 10,803 ug/l Chronic criterion: 1,200 ug/l
Human Health Non-threshold Criteria:
Public and food processing water supply: 47 ug/l
Non-drinking water: 2,600 ug/l
Date criteria derived: June 20, 2006
Applicable waterbodies: Not used during this period.

Chemical: Thallium CAS #7440-28-0
Aquatic Life Criteria:
Acute criterion: 54 ug/l Chronic criterion: 15 ug/l
Human Health Threshold Criteria:
Public and food processing water supply: 1.3 ug/l
Non-drinking water: 3.7 ug/l
Date criteria derived: June 20, 2006; revised November 18, 2008
Applicable waterbodies: Not used during this period.

Chemical: Vinyl Chloride CAS #75-01-4
Aquatic Life Criteria:
Acute criterion: 8,380 ug/l Chronic criterion: 931 ug/l
Human Health Non-threshold Criteria:
Public and food processing water supply: 0.25 ug/l
Non-drinking water: 14.4 ug/l
Date criteria derived: June 20, 2006
Applicable waterbodies: Not used during this period.

For additional information concerning these criteria or the derivation process used in generating them, please contact:

Brian Koch
Illinois Environmental Protection Agency
Division of Water Pollution Control
1021 North Grand Avenue East
Post Office Box 19276
Springfield, Illinois 62794-9276
217-558-2012

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 February 3, 2009 through February 9, 2009 and have been scheduled for review by the Committee at its February 18, 2009 or March 17, 2009 meetings. 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
2/28/09	Secretary of State, Illinois State Library, Acquisitions Division, Illinois Documents Section (23 Ill. Adm. Code 3020)	7/7/08 32 Ill. Reg. 9576	2/18/09
3/19/09	Department of Healthcare and Family Services, Illinois Cares Rx Program (89 Ill. Adm. Code 119)	12/5/08 32 Ill. Reg. 18470	3/17/09
3/20/09	Department of Financial and Professional Regulation, Auction License Act (68 Ill. Adm. Code 1440)	12/19/08 32 Ill. Reg. 19235	3/17/09
3/20/09	Auditor General, Americans With Disabilities Act Grievance Procedure (4 Ill. Adm. Code 1125)	12/5/08 32 Ill. Reg. 18458	3/17/09
3/21/09	Department of Transportation, Airport Hazard Zoning (92 Ill. Adm. Code 16)	12/19/08 32 Ill. Reg. 19462	3/17/09
3/21/09	Department of Transportation, Aurora Municipal Airport Hazard Zoning (Repealer) (92 Ill. Adm. Code 18)	12/19/08 32 Ill. Reg. 19470	3/17/09
3/21/09	Department of Transportation, Casey Municipal Airport Hazard Zoning (Repealer) (92 Ill. Adm.	12/19/08 32 Ill. Reg.	3/17/09

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

	Code 27)	19493	
3/21/09	Department of Transportation, Civic Memorial Airport Zoning Regulations (Repealer) (92 Ill. Adm. Code 30)	12/19/08 32 Ill. Reg. 19516	3/17/09
3/21/09	Department of Transportation, Flora Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 42)	12/19/08 32 Ill. Reg. 19530	3/17/09
3/21/09	Department of Transportation, Greater Kankakee Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 46)	12/19/08 32 Ill. Reg. 19550	3/17/09
3/21/09	Department of Transportation, Mt. Carmel Municipal Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 68)	12/19/08 32 Ill. Reg. 19569	3/17/09
3/21/09	Department of Transportation, Mt. Vernon-Outland Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 70)	12/19/08 32 Ill. Reg. 19588	3/17/09
3/21/09	Department of Transportation, Quincy Municipal Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 75)	12/19/08 32 Ill. Reg. 19607	3/17/09
3/21/09	Department of Transportation, Rochelle Municipal Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 76)	12/19/08 32 Ill. Reg. 19630	3/17/09
3/21/09	Department of Transportation, Shelby County Airport Hazard Zoning Regulations (Repealer) (92 Ill. Adm. Code 78)	12/19/08 32 Ill. Reg. 19650	3/17/09

PROCLAMATIONS

2009-19
Gubernatorial Proclamation

A severe winter storm resulting in heavy accumulations of ice on trees and power lines moved through the seven most southern counties in Illinois on January 26, 2009 through January 28, 2009. The ice storm caused widespread power outages due to downed power lines. Debris from trees covered roads throughout the area. Local governments are faced with a debris removal effort that will take weeks.

In the interest of aiding the local governments responsible for ensuring public health and safety, I find that these events constitute a disaster within the meaning of Section 4 of the Illinois Emergency Management Act (IEMA) 20 ILCS 3365/4 (IEMA), and, accordingly, pursuant to Section 7 of IEMA, I hereby proclaim that disaster areas exist in the following counties: Alexander, Hardin, Johnson, Massac, Pope, Pulaski and Union.

This gubernatorial proclamation of disaster will assist the Illinois Emergency Management Agency in coordinating State resources to support the local governments in their disaster response and recovery efforts.

Issued by the Governor: January 30, 2009.
Filed with the Secretary of State: February 17, 2009.

ILLINOIS ADMINISTRATIVE CODE
Issue Index - With Effective Dates

Rules acted upon in Volume 33, Issue 9 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquiries about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

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