

# 2011

# ILLINOIS

# REGISTER

RULES  
OF GOVERNMENTAL  
AGENCIES



Index Department  
Administrative Code Division  
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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 preemptory 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 2011

<u>Issue #</u>	<u>Rules Due Date</u>	<u>Date of Issue</u>
1	December 20, 2010	January 3, 2011
2	December 27, 2010	January 7, 2011
3	January 3, 2011	January 14, 2011
4	January 10, 2011	January 21, 2011
5	January 18, 2011	January 28, 2011
6	January 24, 2011	February 4, 2011
7	January 31, 2011	February 14, 2011
8	February 7, 2011	February 18, 2011
9	February 15, 2011	February 25, 2011
10	February 22, 2011	March 4, 2011
11	February 28, 2011	March 11, 2011
12	March 7, 2011	March 18, 2011
13	March 14, 2011	March 25, 2011
14	March 21, 2011	April 1, 2011
15	March 28, 2011	April 8, 2011
16	April 4, 2011	April 15, 2011
17	April 11, 2011	April 22, 2011
18	April 18, 2011	April 29, 2011
19	April 25, 2011	May 6, 2011
20	May 2, 2011	May 13, 2011
21	May 9, 2011	May 20, 2011
22	May 16, 2011	May 27, 2011

23	May 23, 2011	June 3, 2011
24	May 31, 2011	June 10, 2011
25	June 6, 2011	June 17, 2011
26	June 13, 2011	June 24, 2011
27	June 20, 2011	July 1, 2011
28	June 27, 2011	July 8, 2011
29	July 5, 2011	July 15, 2011
30	July 11, 2011	July 22, 2011
31	July 18, 2011	July 29, 2011
32	July 25, 2011	August 5, 2011
33	August 1, 2011	August 12, 2011
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42	October 3, 2011	October 14, 2011
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46	October 31, 2011	November 14, 2011
47	November 7, 2011	November 18, 2011
48	November 14, 2011	November 28, 2011
49	November 21, 2011	December 2, 2011
50	November 28, 2011	December 9, 2011
51	December 5, 2011	December 16, 2011
52	December 12, 2011	December 27, 2011
53	December 19, 2011	December 30, 2011

## DEPARTMENT OF EMPLOYMENT SECURITY

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Disqualifying Income And Reduced Benefits
- 2) Code Citation: 56 Ill. Adm. Code 2920
- 3) Section Number: 2920.18      Proposed Action: Amendment
- 4) Statutory Authority: 820 ILCS 405/234, 235, 239, 245, 401, 402, 500.1, 600, 605, 606, 610, 611, 1300, 1700 and 1701
- 5) A Complete Description of the Subjects and Issues Involved: A recent amendment to the Illinois Income Tax Act (PA 96-1496) changed the tax rate for individuals. The rulemaking changes the withholding percentages for State income tax to correspond to the statutory changes and revises examples regarding the calculation of the benefits payable to claimants who have elected State or federal income tax withholding.
- 6) Proposed 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: Yes
- 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 proposed amendment neither creates nor expands any State mandate on units of local government, school districts or community college districts.
- 12) Time, Place and manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments, data, views or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Gregory J. Ramel, Deputy Legal Counsel  
Illinois Department of Employment Security  
33 South State Street – Room 937

## DEPARTMENT OF EMPLOYMENT SECURITY

## NOTICE OF PROPOSED AMENDMENT

Chicago, IL 60603

312-793-4240

Gregory.Ramel@illinois.gov

The Department requests the submission of written comments within 45 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].

This proposed amendment has no 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 and 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 a small business, small municipality or not-for-profit corporation as part of any written comments that they submit to the Department.

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking has no effect on small businesses, small municipalities and not-for-profit corporations.
  - B) Reporting, bookkeeping or other procedures required for compliance: No reporting or bookkeeping is required for compliance.
  - C) Types of professional skills necessary for compliance: None
- 13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking is necessitated by a recent amendment to the Illinois Income Tax Act (PA 96-1496) and replaces an emergency rule.

The full text of the Proposed Amendment is identical to an Emergency Amendment which begins on page 2801 of this Register:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Practice in Administrative Hearings
- 2) Code Citation: 89 Ill. Adm. Code 104
- 3) Section Number: 104.102                      Proposed Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 96-1072
- 5) Complete Description of the Subjects and Issues Involved: This proposed rulemaking implements Public Act 96-1072, effective January 1, 2011, that provides a monetary child support or maintenance order shall not be suspended or stayed due to a post-judgment motion.
- 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 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:

Jeanette Badrov  
General Counsel  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue E., 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

217/782-1233

The Department requests the submission of written comments within 45 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].

- 13) Initial Regulatory Flexibility Analysis:
  - A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - 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 2010

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER a: GENERAL PROVISIONS

PART 104

PRACTICE IN ADMINISTRATIVE HEARINGS

SUBPART A: ASSISTANCE APPEALS

Section

- 104.1 Assistance Appeals
- 104.10 Initiation of Appeal Process
- 104.11 Pre-Appeal Review
- 104.12 Notice of Hearing
- 104.20 Conduct of Hearings
- 104.21 Representation
- 104.22 Appellant Participation in Hearing
- 104.23 Evidentiary Requirements
- 104.30 Subpoenas
- 104.35 Amendment of Appeal
- 104.40 Consolidation of Appeals
- 104.45 Postponement or Continuation of Hearings
- 104.50 Withdrawal of Appeal
- 104.55 Closing of Hearing Record
- 104.60 Dismissal of Appeal
- 104.70 Final Administrative Decision
- 104.80 Public Aid Committee

SUBPART B: RESPONSIBLE RELATIVE AND JOINT PAYEE PETITIONS

Section

- 104.100 Support Order, Responsible Relative and Joint Payee Petitions
- 104.101 Petition for Hearing
- 104.102 Conduct of Administrative Support Hearings
- 104.103 Conduct of Hearings to Contest the Determination of Past-Due Support or of a Failure of a Licensee to Comply with a Subpoena or Warrant in a Paternity or Child Support Proceeding or of Share of Jointly-Owned Federal or State Income Tax Refunds or Other Joint Federal or State Payments
- 104.104 Conduct of Other Hearings

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 104.105 Conduct of Hearings on Petitions for Release from Administrative Paternity Orders
- 104.106 Conduct of Hearings on Petitions for Family Financial Responsibility Driving Permits
- 104.110 Conduct of Hearings on Joint Owner's Contest of Levy of Jointly-Owned Personal Property

## SUBPART C: MEDICAL VENDOR AND ALTERNATE PAYEE HEARINGS

- Section
- 104.200 Applicability
- 104.202 Definitions
- 104.204 Notice of Denial of An Application
- 104.206 Notice of Intent to Recover Money
- 104.207 Notice of Contested Paternity Hearing
- 104.208 Notice of Intent to Terminate, Suspend or Not Renew Provider Agreement or to Revoke Alternate Payee
- 104.209 Notice of Intent to Certify Past-Due Support Owed by a Responsible Relative to, or Failure to Comply with a Subpoena or Warrant from, a State Licensing Agency and to Take Disciplinary Action (Repealed)
- 104.210 Right to Hearing
- 104.211 Notice of Termination or Suspension Pursuant to Exclusion by the Department of Health and Human Services
- 104.212 Prior Factual Determinations
- 104.213 Demand for Judicial Determination of the Existence of the Father and Child Relationship
- 104.215 Notice of Formal Conference
- 104.216 Formal Conference on Recovery of Money
- 104.217 Purpose of Formal Conference
- 104.220 Notice of Hearing
- 104.221 Issues at Hearings
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- 104.226 Appearance of Attorney or Other Representative
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## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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104.245	Witness at Hearings
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104.248	Disqualification of Hearing Officers
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104.271	Continuances and Extensions
104.272	Withholding of Payments During Pendency of Proceedings
104.273	Continuation of Payments During Pendency of Proceedings
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104.280	Record of Hearings
104.285	Failure to Appear or Proceed
104.290	Recommended Decision
104.295	Director's Decision

SUBPART D: RULES FOR JOINT DEPARTMENT ACTIONS AGAINST  
SKILLED NURSING FACILITIES AND INTERMEDIATE CARE  
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Section	
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104.302	Definitions
104.304	Department Actions Against Nursing Homes Facilities
104.310	Certification
104.320	Joint Administrative Hearing
104.330	Facilities Certified Under Both Medicare and Medicaid

## SUBPART E: FOOD STAMP ADMINISTRATIVE DISQUALIFICATION HEARINGS

Section	
104.400	Suspected Intentional Violation of the Program
104.410	Advance Notice of Administrative Disqualification Hearing
104.420	Postponement of Hearing
104.430	Administrative Disqualification Hearing Procedures

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

104.440	Failure to Appear
104.450	Participation While Awaiting a Hearing
104.460	Consolidation of Administrative Disqualification Hearing with Fair Hearing
104.470	Administrative Disqualification Hearing Decision and Notice of Decision
104.480	Appeal Procedure

## SUBPART F: INCORPORATION BY REFERENCE

Section	
104.800	Incorporation by Reference

AUTHORITY: Implementing Sections 11-8 through 11-8.7, 12-4.9 and 12-4.25 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/11-8 through 11-8.7, 12-4.9, 12-4.25 and 12-13].

SOURCE: Filed and effective December 30, 1977; emergency rule at 2 Ill. Reg. 11, p. 151, effective March 9, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 21, p. 10, effective May 26, 1978; amended at 2 Ill. Reg. 33, p. 57, effective August 17, 1978; preemptory amendment at 3 Ill. Reg. 11, p. 38, effective March 1, 1979; amended at 4 Ill. Reg. 21, p.80, effective May 8, 1980; preemptory amendment at 5 Ill. Reg. 1197, effective January 23, 1981; amended at 5 Ill. Reg. 10753, effective October 1, 1981; amended at 6 Ill. Reg. 894, effective January 7, 1982; codified at 7 Ill. Reg. 5706; amended at 8 Ill. Reg. 5274, effective April 9, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg. 16979; amended at 8 Ill. Reg. 18114, effective September 21, 1984; amended at 10 Ill. Reg. 10129, effective June 1, 1986; amended at 11 Ill. Reg. 9213, effective April 30, 1987; amended at 12 Ill. Reg. 9142, effective May 16, 1988; amended at 13 Ill. Reg. 3944, effective March 10, 1989; amended at 13 Ill. Reg. 17013, effective October 16, 1989; amended at 14 Ill. Reg. 18836, effective November 9, 1990; amended at 15 Ill. Reg. 5320, effective April 1, 1991; amended at 15 Ill. Reg. 6557, effective April 30, 1991; amended at 16 Ill. Reg. 12903, effective August 15, 1992; amended at 16 Ill. Reg. 16632, effective October 23, 1992; amended at 16 Ill. Reg. 18834, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 659, effective January 7, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 7025, effective April 30, 1993; amended at 18 Ill. Reg. 11260, effective July 1, 1994; amended at 19 Ill. Reg. 1321, effective January 30, 1995; emergency amendment at 19 Ill. Reg. 10268, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 15521, effective October 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15711, effective November 6, 1995; amended at 20 Ill. Reg. 1229, effective December 29, 1995; amended at 20 Ill. Reg. 5699, effective March 28, 1996; amended at 20 Ill. Reg. 14891, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 8671, effective July 1, 1997, for a maximum of 150 days;

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

emergency amendment at 21 Ill. Reg. 9306, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13648, effective October 1, 1997; amended at 21 Ill. Reg. 14977, effective November 7, 1997; emergency amendment at 22 Ill. Reg. 17113, effective September 10, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 2393, effective January 22, 1999; emergency amendment at 23 Ill. Reg. 11734, effective September 1, 1999, for a maximum of 150 days; amended at 24 Ill. Reg. 2418, effective January 27, 2000; amended at 25 Ill. Reg. 5351, effective April 1, 2001; amended at 26 Ill. Reg. 9836, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11022, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 12306, effective July 26, 2002; amended at 26 Ill. Reg. 17743, effective November 27, 2002; amended at 27 Ill. Reg. 5853, effective March 24, 2003; amended at 27 Ill. Reg. 13771, effective August 1, 2003; amended at 28 Ill. Reg. 2735, effective February 1, 2004; emergency amendment at 29 Ill. Reg. 2735, effective February 7, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 10187, effective June 30, 2005; amended at 31 Ill. Reg. 2387, effective January 19, 2007; amended at 32 Ill. Reg. 16797, effective October 6, 2008; amended at 33 Ill. Reg. 6283, effective April 15, 2009; amended at 35 Ill. Reg. 2030, effective January 21, 2011; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART B: RESPONSIBLE RELATIVE AND JOINT PAYEE PETITIONS

**Section 104.102 Conduct of Administrative Support Hearings**

- a) Hearing De Novo
  - 1) The hearing shall be de novo and the Department's determination of liability or non-liability pursuant thereto shall be independent of the prior determination of liability.
  - 2) In Title IV-D cases, the hearing shall only consider such matters as are relevant for a determination of the duty and financial ability to support under 89 Ill. Adm. Code 160.60 and 160.65.
- b) Rules Governing Hearing
  - 1) Hearings on petitions for release from or modification of the Administrative Support Order shall be governed by Sections 104.10 through 104.70, except that "appellant" as used within this Part shall refer to the responsible relative or Title IV-D client who petitions and except as set out in subsection (b)(2) of this Section.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 2) In Title IV-D cases, the following additional rules shall govern:
- A) A request for appeal must be filed with the regional or central office of the Division of Child Support Enforcement at the address furnished in the administrative support order.
  - B) For purposes of notice and of presenting evidence, the Title IV-D client and the responsible relative shall be considered interested parties.
  - C) Hearings shall be conducted by a hearing officer authorized by the Director of the Department to consider issues under appeal by Title IV-D clients and responsible relatives.
  - D) In the event of cross appeals, if the client is an Illinois resident, the hearing shall be held in the client's county of residence. Otherwise, if the appellant is an Illinois resident, the hearing shall be conducted in the appellant's county of residence. If the appellant is not an Illinois resident but the client is an Illinois resident, the hearing shall be conducted in the client's county of residence. If neither the appellant nor the client is an Illinois resident, the hearing shall be conducted in the appropriate regional office of the Division of Child Support Enforcement. In any event, the hearing may be conducted in a county acceptable to the appellant, the client, and the Division of Child Support Enforcement. If a party is outside the State, he or she may, in a manner consistent with Section 11-8.2 of the Public Aid Code [305 ILCS 5/11-8.2], present his or her case through depositions and witnesses. In addition, a party may request to participate in the hearing by telephone, at his or her own expense.
  - E) Documents certified by a clerk of court or a Title IV-D agency shall be admitted into evidence without further proof. (Refer to Section 104.23 for admission of other evidence.)
  - F) In addition to the appellant, the Division of Child Support Enforcement or Title IV-D client may request and receive a continuance for good cause shown (for example, illness or other circumstance which prevents a party from continuing in the normal course of the hearing).

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- G) Effective January 1, 2011, enforcement of administrative support orders entered under 89 Ill. Adm. Code 160.60 or modified under 89 Ill. Adm. Code 160.65 shall not be stayed pending the filing and resolution of a petition for release from or modification of the administrative support order.
- HG) Following the hearing, the Director of the Department shall make a Final Administrative Decision. A copy of the decision shall be mailed to each interested party and the parties' representatives, if any, within 90 days after the Department's receipt of the request for hearing, extended by any delay caused by any party other than the Department. The Department shall take appropriate action implementing the results of the decision within 30 days after its release.
- c) A hearing to vacate registration or to modify the administrative income withholding notice of the Department shall consider only matters which would be available to the responsible relative as defenses in a civil action in Illinois to enforce a foreign money judgment (such as, payment, partial payment, or identification of the party against whom the judgment was entered). If the responsible relative shows the Department that an appeal from the registered support order is pending or will be taken in the court or administrative body of the jurisdiction which originally entered the order, or that a stay of execution has been granted, the Department shall stay enforcement of the order until the appeal is concluded, the time for appeal has expired, or the stay order is vacated.

(Source: Amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## DEPARTMENT OF INSURANCE

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Minimum Standards For Determining Nonforfeiture Benefits For Certain Life Insurance Policies Having Intermediate Cash Benefits
- 2) Code Citation: 50 Ill. Adm. Code 1415
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1415.10	New
1415.20	New
1415.30	New
- 4) Statutory Authority: Implementing and authorized by Section 229.2 of the Illinois Insurance Code [215 ILCS 5/229.2]
- 5) A Complete Description of the Subjects and Issues Involved: The intent of the Standard Nonforfeiture Law [215 ILCS 5/229.2] is to ensure that life insurance policies provide reasonable nonforfeiture benefits in the event the consumer decides to terminate the policy. A new category of life insurance has emerged offering an endowment benefit or a return of premium benefit prior to the coverage expiry date of the policy. The purpose of this regulation is to provide an interpretation of the Standard Nonforfeiture Law that results in reasonable nonforfeiture benefits for these policies.
- 6) Any published studies or reports, along with the sources of underlying data, that were used when comprising 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 require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

## DEPARTMENT OF INSURANCE

## NOTICE OF PROPOSED RULES

Eve Blackwell-Lewis  
Senior Staff Attorney  
Department of Insurance  
320 West Washington , 4<sup>th</sup> Floor  
Springfield, Illinois 62767-0001

or

Susan Anders  
Rules Coordinator  
Department of Insurance  
320 West Washington, 4<sup>th</sup> Floor  
Springfield, Illinois 62767-0001

217/782-2867  
217/524-9033 (fax)

217/785-8220

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance:  
Methodology as set forth in Section 30
  - C) Types of professional skills necessary for compliance: Actuarial
- 14) Regulatory Agenda on which this rulemaking was summarized: July 2010

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

## DEPARTMENT OF INSURANCE

## NOTICE OF PROPOSED RULES

## TITLE 50: INSURANCE

## CHAPTER I: DEPARTMENT OF INSURANCE

## SUBCHAPTER s: LEGAL RESERVE LIFE INSURANCE

## PART 1415

## MINIMUM STANDARDS FOR DETERMINING NONFORFEITURE BENEFITS FOR CERTAIN LIFE INSURANCE POLICIES HAVING INTERMEDIATE CASH BENEFITS

## Section

1415.10	Scope
1415.20	Purpose
1415.30	Methodology

AUTHORITY: Implementing and authorized by Section 229.2 of the Illinois Insurance Code [215 ILCS 5/229.2].

SOURCE: Adopted at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 1415.10 Scope**

- a) This Part applies to individual life insurance policies, other than variable and non-variable adjustable life policies and current assumption whole life policies, that provide for an endowment benefit, materially less than the policy face amount, at a specified intermediate duration during a longer period of life insurance protection. The payment of an endowment benefit does not alter or eliminate any premiums or benefits scheduled for the period subsequent to the endowment date, nor does the policy automatically terminate upon payment of the endowment benefit. Policies that offer a return of premium endowment benefit may be considered a special case of the policies subject to this Part.
- b) Other products within the scope designed to provide similar benefits and having similar premium structures (for example, products having a cash value at the end of an initial level premium period equal to the total premiums paid) would be expected to provide minimum cash values that are determined in a manner consistent with this Part. For products with multiple endowment benefits, the minimum cash values should be determined in accordance with the principles of this Part.

**Section 1415.20 Purpose**

## DEPARTMENT OF INSURANCE

## NOTICE OF PROPOSED RULES

The purpose of this Part is to establish minimum standards for nonforfeiture values for certain life insurance policies having intermediate cash values, as described in Section 10 of this Part.

**Section 1415.30 Methodology**

- a) The following methodology shall be used in the determination of minimum cash surrender values for policies subject to this Part in accordance with the requirements of Section 229.2 of the Insurance Code (Standard Nonforfeiture Law for Life Insurance) [215 ILCS 5/229.2].
  - 1) The endowment period shall be that period of time measured from the issue date of the policy to the date when the endowment benefit becomes payable (the endowment date) under the terms of the policy.
  - 2) If the endowment benefit is added by rider to a policy, then, for minimum cash value determination purposes, the base policy and the endowment benefit are to be treated as integrated.
  - 3) Premiums under the policy may be provided through a scale of guaranteed rates for the term of the policy or through a scale of current rates that are subject to a scale of guaranteed maximum premiums; if rates are subject to a scale of guaranteed maximum premiums, the minimum cash values shall be the greater of those produced under this Part using the guaranteed maximum rates and current rate scale applicable at issue of the policy.
  - 4) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary during the endowment period shall be an amount not less than the excess, if any, of the present value, on the anniversary, of the endowment benefit and any future incremental death benefits during the endowment period that would have been provided for by the policy if there had been no default, over the sum of:
    - A) The then present value of the adjusted premiums as defined in subsection (a)(6) corresponding to premiums that would have fallen due on and after the anniversary during the endowment period; and

## DEPARTMENT OF INSURANCE

## NOTICE OF PROPOSED RULES

- B) The amount of any indebtedness to the company on the policy.
- 5) Incremental death benefits are death benefits during the endowment period in excess of the lowest death benefit provided under the policy during the endowment period.
- 6) The adjusted premiums for the policy shall be calculated on an annual basis and shall be the uniform percentage of the respective premiums specified in the policy for each policy year during the endowment period, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:
- A) The present value of the endowment benefit and any incremental death benefits provided for by the policy during the endowment period;
- B) 1% of the average amount of insurance (total death benefit under the policy, including any incremental death benefits) at the beginning of each of the first 10 policy years; and
- C) 125% of the nonforfeiture net level premium, as defined in subsection (a)(7); provided, however, that no nonforfeiture net level premium shall be considered to exceed 4% of the average amount of insurance (total death benefit under the policy, including any incremental death benefits) at the beginning of each of the first 10 policy years.
- 7) The nonforfeiture net level premium for the policy shall be equal to the present value, at the date of issue of the policy, of the endowment benefit and any incremental death benefits provided for by the policy during the endowment period, divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due prior to the endowment date.

## DEPARTMENT OF INSURANCE

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- 8) The mortality rates and interest rate used in the determination of the minimum cash values for the policy shall be those applicable under Section 229.2 of the Insurance Code, considering during the entire period death benefits are guaranteed available under the policy, subject only to the payment of required premiums.
- b) In no event can the cash surrender value under the policy at any duration be less than the greater of:
    - 1) The minimum cash value calculated according to Section 30(a) of this Part; and
    - 2) The minimum cash value at the same duration resulting from the application of the methods described in Section 229.2(3) and (4c) of the Code, considering guaranteed benefits and premiums (whether guaranteed or indeterminate) during the entire period death benefits are guaranteed available under the policy, subject only to the payment of required premiums. In performing this calculation, no annual premium at any duration after the endowment period shall exceed the difference between the death benefit and the cash value at that duration.
  - c) The cash surrender values for the policy must also satisfy the consistency of progression of cash values test contained in Section 229.2(7) of the Code, considering guaranteed benefits and premiums (whether guaranteed or indeterminate) during the entire period death benefits are guaranteed available under the policy, subject only to the payment of required premiums.
  - d) For policies in which the benefit is defined in more general terms as providing for a return of premiums paid or a portion of premiums paid, the procedures of Section 229.2(4c)(c) of the Code and the requirements of Section 30(a) of this Part shall be applied in the determination of a revised set of minimum cash values in the event the value of the endowment benefit of the policy changes due to a change made to the premium schedule provided.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Approval of Racing Officials
- 2) Code Citation: 11 Ill. Adm. Code 422
- 3) Section Number: 422.10                      Proposed Action:  
Amend
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking shortens the 60 day notice requirement to 20 days for racetracks to submit their list of racing officials. The Board has determined that the 60 day requirement is unrealistic because racetracks, in some cases, are still in the process of securing a full complement of racing officials.
- 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 in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo  
Illinois Racing Board  
100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601

ILLINOIS RACING BOARD

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312/814-5017

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
 SUBTITLE B: HORSE RACING  
 CHAPTER I: ILLINOIS RACING BOARD  
 SUBCHAPTER b: RULES APPLICABLE TO ORGANIZATION LICENSEES

PART 422  
 APPROVAL OF RACING OFFICIALS

## Section

422.10	Racing Officials
422.20	Approval of New Officials
422.30	Standards for Approval and Disapproval of Officials
422.40	Recommendation of Board
422.50	Suspension and Removal of Officials
422.60	Conflict of Interest Provisions
422.70	Emergency Approval
422.80	Physical Examination
422.90	Officials Approved by the Stewards
422.100	Occupation License
422.110	Penalties

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Adopted at 5 Ill. Reg. 10341, effective September 25, 1981; codified at 5 Ill. Reg. 10905; amended at 10 Ill. Reg. 10141, effective May 27, 1986; amended at 13 Ill. Reg. 1558, effective January 23, 1989; amended at 16 Ill. Reg. 13069, effective August 10, 1992; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 422.10 Racing Officials**

- a) Each organization licensee shall submit to the Board for its approval or disapproval the names of all persons whom the licensee has selected as racing officials or employees whose duties relate to the actual running of the races. The list shall include, when~~where~~ applicable, the following thoroughbred and harness racing officials:

Association Steward  
 Presiding Judge

Marshal or Outrider  
 Timer

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

Associate Judge	Clerk of the Scales
Racing Secretary	Clerk of Course
Assistant Racing Secretary	Track Veterinarian
Patrol Judges	Track Superintendent
Placing Judges	Mutuel Manager
Paddock Judges	Program Director
Breathalyzer Operator	Director of Security
Starter	General Manager

- b) The list of names shall be submitted to the Board in writing at least ~~2060~~ days prior to the opening of any race meeting and the list shall indicate whether the nominee has previously been employed at any Illinois race track.

(Source: Amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Medication
- 2) Code Citation: 11 Ill. Adm. Code 603
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
603.70	Amend
603.90	Amend
603.210	Amend
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendment to Section 603.70(b)(1)(2) corrects typographical errors. The proposed amendment to Section 603.90 adds written approval from the "Executive Director or his designee" and expands the list of prohibited substances to include Bee Venom. The proposed amendment to Section 603.210 expands testing for steroids to include plasma thresholds for four anabolic steroids.
- 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 in this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Register Citation:</u>
603.60	Amendment	35 Ill. Reg. 185; January 3, 2011
603.75	Amendment	35 Ill. Reg. 185; January 3, 2011
603.160	Amendment	35 Ill. Reg. 185; January 3, 2011
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:  
Mickey Ezzo  
Illinois Racing Board  
100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601  
  
312/814-5017
- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: January 2011

The full text of the Proposed Amendments is identical to the Emergency Amendments for this Part, and can be found in this issue of the Illinois Register on page 2810.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Racing Rules
- 2) Code Citation: 11 Ill. Adm. Code 1318
- 3) Section Number: 1318.190                      Proposed Action:  
Amend
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- 5) A Complete Description of the Subjects and Issues Involved: This proposed rulemaking corrects the discrepancy between Section 1318.190 and Section 1318.180. In Section 1318.180, the stewards may disqualify a horse that violates the rule but in Section 1318.190(b)(3), the stewards shall disqualify a horse that violates the rule.
- 6) Published studies or reports and sources of underlying data used to compose this rulemaking: None
- 7) Will this proposed 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 in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo  
Illinois Racing Board  
100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

312/814-5017

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
SUBTITLE B: HORSE RACING  
CHAPTER I: ILLINOIS RACING BOARD  
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1318  
RACING RULES

## Section

1318.10	Racing Conduct
1318.20	Complaints
1318.30	Disqualification of Entries
1318.40	Penalties
1318.50	Unsatisfactory Driving
1318.60	Driver Substitution
1318.70	Failure to Finish
1318.80	Improper Conduct
1318.90	Use of the Whip
1318.100	Goading Devices (Repealed)
1318.110	Accidents
1318.120	Use of Hopples
1318.130	Breaking
1318.140	Breaking on Purpose
1318.150	Call Out Breaks
1318.160	Right of Course
1318.170	Penalties
1318.180	Harness Tracks Without a Continuous Hub Rail
1318.190	Open Stretch Racing

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing (original date not cited in publication); adopted December 22, 1977, filed December 30, 1977; codified at 5 Ill. Reg. 10945; amended at 5 Ill. Reg. 13719, effective December 2, 1981; emergency amendment at 15 Ill. Reg. 15610, effective October 10, 1991, for a maximum of 150 days; emergency expired March 8, 1992; amended at 16 Ill. Reg. 7489, effective April 27, 1992; amended at 17 Ill. Reg. 19303, effective October 25, 1993; amended at 22 Ill. Reg. 7049, effective May 1, 1998; amended at 28 Ill. Reg. 14658, effective November 1, 2004; amended at 29 Ill. Reg. 14043,

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

effective September 1, 2005; amended at 30 Ill. Reg. 9188, effective May 1, 2006; amended at 34 Ill. Reg. 2324, effective January 27, 2010; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 1318.190 Open Stretch Racing**

- a) With approval of the Board, a track may extend the width of its homestretch up to 10 feet inward in relation to the width of the rest of the racetrack. The criteria for Board approval shall include, but not be limited to, the size of the race track, the length of the homestretch, the necessity for conversion from harness to thoroughbred racing surfaces and rails, and the type of existing rail.
- b) In the event the home stretch is expanded pursuant to subsection (a), the following shall apply:
  - 1) No horse shall pass on the extended inside lane entering the stretch the first time on a ½ mile track.
  - 2) The lead horse in the homestretch shall maintain as straight a course as possible while allowing trailing horses full access to the extended inside lane.
  - 3) Horses using the open stretch must first have complete clearance of the pylons. Any horse or sulky running over the pylons and/or going to the inside of the pylons to clear ~~may~~ be disqualified.
  - 4) No horse may be driven into the open stretch for the purpose of blocking or impeding a trailing horse. It shall be presumed that a horse that blocks or impedes a trailing horse in the open stretch without advancing on a leading horse is being driven for the purpose of blocking or impeding a trailing horse. Violation of this provision may result in a disqualification, and the driver may be fined.

(Source: Amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Security and Admissions
- 2) Code Citation: 11 Ill. Adm. Code 1325
- 3) Section Number: 1325.80                      Proposed Action:  
Amend
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)]
- 5) A Complete Description of the Subjects and Issues Involved: Section 27(f) of the Horse Racing Act states that any municipality or county that has a Board licensed inter-track wagering location facility wholly within its corporate boundaries, may each impose an admission fee not to exceed \$1.00 per admission to the inter-track wagering location facility, so that a total of not more than \$2.00 per admission may be imposed. This proposed rulemaking requires OTB's that charge an admission fee to submit those fees to the Board within 48 hours and the Board shall remit those monies to the municipalities on a monthly basis.
- 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 in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo  
Illinois Racing Board  
100 West Randolph

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

Suite 7-701  
Chicago, Illinois 60601

312/814-5017

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
SUBTITLE B: HORSE RACING  
CHAPTER I: ILLINOIS RACING BOARD  
SUBCHAPTER f: RULES AND REGULATIONS OF HARNESS RACING

PART 1325  
SECURITY AND ADMISSIONS

Section	
1325.10	Stable Enclosures Fenced
1325.20	Report of Arrival and Departure of Horses
1325.30	Stable Area Security
1325.40	Policing of Premises
1325.50	Admission to Parts of Premises
1325.60	Identification Cards and Badges
1325.70	Admission Statements
1325.80	<del>State</del> -Admissions Tax
1325.90	Admissions Records
1325.100	Board Approval of Tickets and Credentials
1325.110	Credential and Ticket Specimens
1325.120	Tax Exempt Credentials
1325.130	Tax Exempt Credentials Report (Repealed)
1325.140	Track Responsible for Credentials
1325.150	Board Access to Records
1325.160	Turnstiles and Electronic Scanning Devices
1325.170	Admission to Track
1325.180	Revocation of Credentials
1325.190	Inspections and Searches (Repealed)
1325.200	Investigative Authority

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

SOURCE: Published in Rules and Regulations of Harness Racing, (original date not cited in publication); amended October 25, 1973, filed November 26, 1973; amended March 14, 1975, filed and effective March 27, 1975; amended May 9, 1975, filed May 15, 1975; amended at 4 Ill. Reg. 41, p. 164, effective September 26, 1980; codified at 5 Ill. Reg. 10955; amended at 14 Ill. Reg. 17665, effective October 16, 1990; amended at 15 Ill. Reg. 5748, effective April 4, 1991;

## ILLINOIS RACING BOARD

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amended at 31 Ill. Reg. 15099, effective November 1, 2007; amended at 32 Ill. Reg. 16498, effective October 1, 2008; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 1325.80 State Admissions Tax**

- a) The race track operator shall pay to the Board at such time or times as the Board shall prescribe, the sum of 1540 cents for each person entering the grounds or enclosure of the race track operator upon a ticket of admission. If tickets are issued for more than one day, then the sum of 1540 cents shall be paid for each person using ~~thesueh~~ ticket each day that ~~the ticket is the same shall be~~ used. ~~No~~ Provided that no charge shall be made on tickets issued to and in the name of directors, officers, partners, agents or employees of the race track operator, or to owners, trainers and drivers and their employees, or to any person or persons entering the grounds for the transaction of business in connection with ~~thesueh~~ race meeting. ~~No~~ Provided further that no charge shall be made on tax exempt tickets of admission issued by the Board.
- b) Pursuant to ~~subsection (a) the above paragraph~~, the State Director of Mutuels shall direct and supervise the conduct of the admissions department during each race meeting. ~~The State Director~~ He shall be empowered to direct the race track operator to adopt, subject to the approval of the Board, procedures, methods and systems as may be deemed necessary to ensure strict compliance with the rules and regulations of the Board.
- c) Intertrack wagering location licensees shall pay to the Board, within 48 hours, any admission taxes due to local municipalities.
- d) The Board shall remit monthly any admission taxes due to local municipalities.

~~(Editor's Note: Section 25 of the Illinois Horse Racing Act of 1975 (Ill. Rev. Stat. 1979, chap. 8 par. 37-25) now provides for a 15 cents admissions tax instead of 40 cents)~~

(Source: Amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Admissions and Credentials
- 2) Code Citation: 11 Ill. Adm. Code 1428
- 3) Section Number: 1428.10                      Proposed Action: Amend
- 4) Statutory Authority: Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].
- 5) A Complete Description of the Subjects and Issues Involved: Section 27(f) of the Horse Racing Act states that any municipality or county that has a Board licensed inter-track wagering location facility wholly within its corporate boundaries may each impose an admission fee not to exceed \$1.00 per admission to the inter-track wagering location facility, so that a total of not more than \$2.00 per admission may be imposed. This proposed rulemaking requires OTB's that charge an admission fee to submit those fees to the Board within 48 hours and the Board shall remit those monies to the municipalities on a monthly basis.
- 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 in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo  
Illinois Racing Board  
100 West Randolph

ILLINOIS RACING BOARD

NOTICE OF PROPOSED AMENDMENT

Suite 7-701  
Chicago, Illinois 60601

312/814-5017

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the Board did not anticipate the need for this rulemaking at the time the agendas were published.

The full text of the Proposed Amendment begins on the next page.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
SUBTITLE B: HORSE RACING  
CHAPTER I: ILLINOIS RACING BOARD  
SUBCHAPTER g: RULES AND REGULATIONS OF HORSE RACING  
(THOROUGHBRED)

PART 1428  
ADMISSIONS AND CREDENTIALS

## Section

1428.10	<del>State</del> -Admissions Tax
1428.20	Admission Records
1428.30	Weekly Remittance of Tax
1428.40	Admission Statements
1428.50	Delivery of Reports
1428.60	Board Approval of Tickets and Credentials
1428.70	Control Numbers
1428.80	Revocation of Tickets, Credentials
1428.90	Notice of State Tax
1428.100	Credential and Ticket Specimens
1428.110	Gate Cards
1428.120	Tax Exempt Credentials
1428.130	Report on Tax Exempt Credentials (Repealed)
1428.140	Concessionaires, Employees Credentials
1428.150	Requisitions for Passes
1428.160	Tax Exempt Credentials Report (Repealed)
1428.170	Summary of Tickets and Credentials
1428.180	Track Responsible for Credentials
1428.190	Board Access to Records
1428.200	Turnstiles and Electronic Scanning Devices
1428.210	Admission to Track
1428.220	Revocation of Credentials
1428.230	Admissions for Licensees
1428.240	Intertrack Wagering Location Licensee Admission Fees

AUTHORITY: Authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENT

SOURCE: Published in Rules and Regulations of Horse Racing (original date not cited in publication); amended March 14, 1975, filed and effective March 27, 1975; codified at 5 Ill. Reg. 11002; amended at 14 Ill. Reg. 17633, effective October 16, 1990; amended at 14 Ill. Reg. 20042, effective December 4, 1990; emergency amendment at 17 Ill. Reg. 3683, effective March 4, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 14049, effective August 16, 1993; amended at 19 Ill. Reg. 17187, effective January 1, 1996; amended at 31 Ill. Reg. 15103, effective November 1, 2007; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 1428.10 ~~State~~ Admissions Tax**

- a) The race track operator shall pay to the Board at such time or times as the Board shall prescribe, the sum of 1540 cents for each person entering the grounds or enclosure of the race track operator upon a ticket of admission. If tickets are issued for more than one day, then the sum of 1540 cents shall be paid for each person using thesueh ticket each day that the ticket issame shall be used. NoProvided that no charge shall be made on tickets issued to and in the name of directors, officers, partners, agents or employees of the race track operator, or to owners, trainers and drivers and their employees, or to any person or persons entering the grounds for the transaction of business in connection with thesueh race meeting. NoProvided further that no charge shall be made on tax exempt tickets of admission issued by the Board.
- b) Pursuant to subsection (a)the above paragraph, the State Director of Mutuels shall direct and supervise the conduct of the admissions department during each race meeting. The State DirectorHe shall be empowered to direct the race track operator to adopt, subject to the approval of the Board, procedures, methods and systems as may be deemed necessary to ensure strict compliance with the rules and regulations of the Board.
- c) Intertrack wagering location licensees shall pay to the Board, within 48 hours, any admission taxes due to local municipalities.
- d) The Board shall remit monthly any admission taxes due to local municipalities.

(Editor's Note: Section 25 of the Illinois Horse Racing Act of 1975 (Ill. Rev. Stat. 1979, ch. 8 par. 37-25) now provides for an admission tax of 15 cents instead of 40 cents)

(Source: Amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## DEPARTMENT OF AGRICULTURE

## NOTICE OF ADOPTED AMENDMENT

- 1) Heading of Part: Egg and Egg Products Act
- 2) Code Citation: 8 Ill. Adm. Code 65
- 3) Section Number: 65.210                      Adopted Action:  
Amendment
- 4) Statutory Authority: Implementing and authorized by Section 13 of the Illinois Egg and Egg Products Act [410 ILCS 615/13]
- 5) Effective Date of Amendment: April 1, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: October 15, 2010; 34 Ill. Reg. 15590
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No agreements were necessary.
- 13) Will this rulemaking replace any emergency amendment currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendment: Pursuant to PA 96-1310, the Agency is increasing the amount of inspection fee paid per case of shell eggs from 6 cents per case to 11 cents per case.
- 16) Information and questions regarding this adopted amendment shall be directed to:

Linda Rhodes

DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

Illinois Department of Agriculture  
P. O. Box 19281, State Fairgrounds  
Springfield, Illinois 62794-9281

Telephone: 217/785-5713

Facsimile: 217/785-4505

The full text of the Adopted Amendment begins on the next page:

## DEPARTMENT OF AGRICULTURE

## NOTICE OF ADOPTED AMENDMENT

TITLE 8: AGRICULTURE AND ANIMALS  
CHAPTER I: DEPARTMENT OF AGRICULTURE  
SUBCHAPTER b: ANIMALS AND ANIMAL PRODUCTS  
(EXCEPT MEAT AND POULTRY INSPECTION ACT REGULATIONS)

PART 65  
EGG AND EGG PRODUCTS ACT

## Section

65.10	Definitions and Incorporations
65.20	Packaging Material, Master Containers, Packing Material and Consumer-Size Containers
65.30	Consumer Container Labeling Requirements
65.40	Restrictions
65.50	Master Container Labeling Requirements
65.60	Advertising
65.70	Brand or Firm Name
65.80	Food Preparation
65.90	Holding Temperature
65.100	Application for License or Renewal; Revocation or Suspension of License
65.110	Licenses
65.120	Surety Bond or Certificate of Deposit (Repealed)
65.130	Required Forms and Records
65.140	Minimum Sanitation, Building and Labeling Requirements for Egg Breaking Establishments
65.150	Minimum Sanitation and Operating Requirements for Shell Egg Grading Plants, Not Under Federal Inspection, Engaged in the Grading, Storage, Packaging and Distribution of Eggs
65.160	Minimum Sanitation Requirements for Retailers and Institutional Consumers
65.170	Retail Egg Inspection
65.180	Enforcement
65.190	Restricted Eggs (Definition, Labeling, Handling, Disposition)
65.200	Denaturants
65.210	Egg Inspection Fee
65.220	Illinois Grade Standards
65.230	Administrative Hearings (Repealed)

AUTHORITY: Implementing and authorized by Section 13 of the Illinois Egg and Egg Products Act [410 ILCS 615/13].

## DEPARTMENT OF AGRICULTURE

## NOTICE OF ADOPTED AMENDMENT

SOURCE: Rules and Regulations for the Illinois Egg and Egg Products Act, filed October 28, 1975, effective November 1, 1975; amended March 2, 1976, effective March 12, 1976; amended December 29, 1976, effective January 1, 1977; codified at 5 Ill. Reg. 10449; amended at 7 Ill. Reg. 2311, effective February 14, 1983; amended at 17 Ill. Reg. 6749, effective April 27, 1993; amended at 19 Ill. Reg. 16933, effective January 1, 1996; amended at 21 Ill. Reg. 900, effective January 7, 1997; amended at 28 Ill. Reg. 2072, effective February 1, 2004; amended at 29 Ill. Reg. 14774, effective October 1, 2005; amended at 35 Ill. Reg. 2578, effective April 1, 2011.

**Section 65.210 Egg Inspection Fee**

- a) An inspection fee of ~~11¢~~ per case (30 dozen equals a case) or fraction of a case shall be imposed on all eggs bearing a designated size and grade that are offered for sale or sold in the State of Illinois.
- b) The first handler in Illinois who packed and sold the eggs shall pay the prescribed inspection fee on the eggs. In the event that the eggs are shipped into Illinois, the handler who invoiced the eggs to Illinois shall pay the fee.
- c) The handler paying the inspection fee shall indicate on each sales invoice the amount of the inspection fee for the transaction in addition to the price of the eggs.
- d) Eggs sold or shipped out of the State of Illinois are exempt from inspection fees.
- e) The inspection fee shall be paid only once on the same quantity of eggs, so long as the eggs maintain their identity by remaining in their original case, carton or container. If eggs are removed from the original case, carton or container, they are now reidentified, and a second inspection fee (same rate as the first fee) shall be paid on the eggs to the Department.
- f) Persons responsible for the payment of the inspection fees shall report every three months the number of master containers (cases of 30 dozen eggs per case) of eggs subject to the inspection fee on forms supplied by the Department. Exception: Persons selling less than 600 master containers of eggs per year subject to the inspection fee shall report the number of master containers sold and remit fees on an annual basis at the time of license renewal. ~~TheSuch~~ reports shall be accompanied by a remittance in an amount corresponding to the number of master containers at the rate prescribed per master container.

## DEPARTMENT OF AGRICULTURE

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- 1) The Director shall summon the delinquent person or firm to an administrative hearing in Springfield in which the license may be suspended or revoked if:
  - A) the quarterly report is established as being false or incorrect; or
  - B) the report is not received within 30 days after the due date.
- 2) The quarters are as follows: January 1 to March 31; April 1 to June 30; July 1 to September 30; October 1 to December 31.
- g) The inspection fee applies to all eggs identified with a consumer Grade "AA", "A", or "B" packed loose or packaged in cartons.

(Source: Amended at 35 Ill. Reg. 2578, effective April 1, 2011)

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Regionalized Perinatal Health Care Code

2) Code Citation: 77 Ill. Adm. Code 640

3) Section Numbers:                      Adopted Action:

640.10	Repeal
640.20	Amend
640.25	Amend
640.30	Amend
640.40	Amend
640.41	Amend
640.42	Amend
640.43	Amend
640.44	Amend
640.45	Amend
640.50	Amend
640.60	Amend
640.70	Amend
640.80	Amend
640.85	New
640.90	Amend
640.100	Amend
640.APPENDIX A	Amend
640.APPENDIX B	Repeal
640.EXHIBIT A	Repeal
640.EXHIBIT B	Repeal
640.APPENDIX C	Repeal
640.EXHIBIT A	Repeal
640.EXHIBIT B	Repeal
640.APPENDIX F	Repeal
640.EXHIBIT A	Repeal
640.EXHIBIT B	Repeal
640.APPENDIX G	Amend
640.APPENDIX H	Amend
640.EXHIBIT A	Amend
640.EXHIBIT B	Amend
640.EXHIBIT C	Amend
640.EXHIBIT D	Amend
640.APPENDIX I	Amend

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

640.APPENDIX J	New
640.APPENDIX K	New
640.APPENDIX L	New
640.APPENDIX M	New
640.APPENDIX N	New
640.APPENDIX O	New

- 4) Statutory Authority: Developmental Disability Prevention Act [410 ILCS 250]
- 5) Effective Date of Rulemaking: January 31, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? Yes
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendments Published in Illinois Register: February 5; 2010; 34 Ill. Reg. 2087
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version:

The following changes were made in response to comments received during the first notice or public comment period:

1. In the Table of Contents, "640.85 Exceptions to Part 640" was added; "Repealed" was deleted after Section 640.100; in 640.APPENDIX H, "Referral" was stricken and "Consultation" was added.
2. In Section 640.20, the definitions of "Administrative Perinatal Center" and "Assisted Ventilation" were amended; definitions of "Advance Practice Nurse", "Essential Resource", and "Refer" were added; and the definition of "Perinatal Center" was stricken.
3. In the definition of "High-Risk Infant" in Section 640.20, "840.210" was stricken and "840.200" was added.

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

4. References to "Administrative Perinatal Center" and "Perinatal Advisory Committee" were changed to "APC" and "PAC" throughout the Part.
5. In the definitions of "Neonatal Intensive Care Unit" and "Special Care Nursery" in Section 640.20, "/perinatal" as added after "neonatal".
6. In the definition of "Regional Perinatal Network" in Section 640.20, "hospital-based" was stricken and "hospitals providing" was added; "facilities functioning" was stricken and "services" was added; "of five" was deleted; "one" was stricken; and "a designated level" was added.
7. In Section 640.25, subsection (c)(2) was added.
8. In Section 640.30(c)(1)(I), "certified" was added before "local".
9. In Section 640.30(e), "Nurses Section of the American College of Obstetricians and Gynecologists," was stricken and "Section, Association of Womens Health, Obstetric and Neonatal Nursing (AWHONN), the National Association of Neonatal Nurses:" was added.
10. In Section 640.40(a), "five" was deleted and "of care" was added after "levels".
11. In Section 640.40(c), "60" was changed to "90".
12. In Section 640.41(b)(2), "Appendix B and Appendix C of Guidelines for Perinatal Care" was changed to "Section 640.Appendix H.Exhibit A".
13. Section 640.41(b)(4) was changed from "Hospitals shall have the capability of performing caesarean sections within 30 minutes after deciding to make an incision." to "Hospitals shall provide caesarean section decision-to-incision capabilities within 30 minutes."
14. In Section 640.41(d)(4), "," blood gases, and routine urinalysis" was added after "hematocrit"; "blood gases," was stricken; "and" was deleted; "routine urinalysis in" was stricken; "one" was deleted; and "hour;" was stricken.
15. In Section 640.41(d)(5) and Section 640.42(d)(9), "nationally recognized" was added before "neonatal" and "licensed" was stricken in 640.41(d)((5)).

## DEPARTMENT OF PUBLIC HEALTH

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16. In Section 640.42(b)(2), "with the APC" was added after "agreement"; "Appendix B and Appendix C of Guidelines for Perinatal Care" was deleted and "Section 640. Appendix H. Exhibit B." was added; and after the stricken text, "Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patients physician and the maternal-fetal medicine subspecialist." was added.
17. In Section 640.42, subsection (b)(3), was stricken and subsection (b)(4) was changed to (b)(3).
18. In Section 640.42(c)(3)(B), "or equal to" was stricken.
19. In Section 640.42(f)(2), new text was deleted and existing text was stricken in the last sentence and the following was added: "Both the letter of agreement with the APC and the hospital's department of pediatrics' policies and procedures shall identify conditions that might require transfer to a Level III hospital, including, but not limited to:".
20. In Section 640.42(f)(2)(C), "All conditions" was changed to "Conditions".
21. In Section 640.42(g)(2)(A), "a pediatrician receiving postgraduate training in a neonatal perinatal medicine fellowship program accredited by the Accreditation Council of Graduate Medical Education;" was deleted.
22. In Section 640.43(a)(1), "maternal-fetal" was changed to "maternal-~~fetal~~".
23. In Section 640.43(b)(3), "hospital" was added after "Level III" and "Administrative Perinatal Center" was changed to "APC Level III hospital".
24. In Section 640.43(c)(8), "or a pediatrician receiving postgraduate training in a neonatal-perinatal medicine fellowship program accredited by the Accreditation Council of Graduate Medical Education" was deleted.
25. In Section 640.43(c)(18), "dedicated" was changed to "available".
26. In Section 640.50(c), "and Outcome Oriented Data (see Appendix B)" was stricken.

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27. In Section 640.60(a)(6)(C) and (D), "to another health care provider" was added after "referral" in (C) and after "services" in (D).

28. In Section 640.70(i) "to another health care provider" was added after "referral services".

29. In Section 640.80(a), "hospital-based" was stricken and "hospitals providing" was added; "facilities" was stricken and "services" was added; "functioning" was stricken; and "five" was deleted.

30. A new Section 640.85 titled "Exceptions to Part 640" was added.

31. In Section 640.90(c)(4), "State" was deleted; "and will be included in the Perinatal Reporting System. However," was stricken; a period was added after "outcome"; "These" was added before "fetal deaths"; "these deaths" was stricken; and "they" was added.

32. In Section 640.90(d)(3), "the Department's Freedom of Information" was stricken; "Code" was deleted; and "Access to Public Records of the Department of Public Health" was added.

33. "**(Repealed)**" was deleted in the heading of Section 640.100.

34. In Section 640.100, the following was added: "The Illinois Department of Human Services manages the high-risk follow-up program in accordance with the Maternal and Child Health Services Code (77 Ill. Adm. Code 630)."

35. Changes to Appendix A:

In the table following "**B. MATERNAL DATA:**

"200", "200" and "201" were added in the middle three boxes in the top row.

"see above" was added after "Delivery Rooms (LDR)".

A new "c. LDRP" was added and "c." was changed to "d.".

"Total Number of Deliveries" was changed to "Total Number of Women Delivering".

An asterisk ("\*") was added before "Forceps" and "Vacuum Extraction".

After "4. Number of C/Sections" the period was deleted and "-add percents #/%" was added.

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In the first, second, and third small columns after Total", "Primary", "Repeat", and "5. Number of Vaginal Births After Cesarean" "/%" was added.

After "5. Number of Vaginal Births After Cesarean", "(VBAC) – add percent #/%" was added.

"+" was added before "7.".

On the line after "7." "\*use final delivery modality" was added and "+ augmentation – stimulation of contractions when spontaneous contractions have failed to progress dilation or descent" was added.

In the table following "C. Neonatal Data":

In the first three columns after "1. Number of nursery beds:", "200", "200", and "201" were added.

In "2.", "SCN" to was changed to "Special Care Nursery\*" and "(level II or II with extended capabilities)" was added.

In "3." "(Level III only)" was added after "NICU"

Under the table, "\*Provide explanation of how average daily census in Special Care Nursery was calculated" was added.

In "1.", "(add percent for LBW and VLBW in shaded areas)" was added.

In the table after "1.":

"200", "200" and "201" were added in the last three boxes of the top row.

"/" was added in the middle of the last three boxes in each row.

After "<500 grams" the numbers in each of the other boxes were changed to read as follows: "500-749"; "750-999"; "1000-1249", "1250-1499"; a new box reading "**Percent for VLBW**" was added and the remaining boxes in the new row were shaded; numbers were changed to read: "1500-1999"; "2000-2499"; a new box reading "**Percent for LBW**" was added and the remaining boxes in the new row were shaded; numbers were changed to read: "2500-2999" "3000-3499"; "3500-3999"; "4000-4499"; "4500-4999"; "5000 – plus".

A new row was added to table "2" with "**Use <1500 gram VON data**" in the first box and "200", "200", and "201" in the remaining boxes.

In table "2":

"Grade III and IV" was changed to "Grade III" with "Grade IV" underneath.

After "Broncho-pulmonary dysplasia" a new row was added with "**\*Use all babies for the categories below**" in the first box.

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

After "Respiratory Distress Syndrome", "(ICD 9 code 769) was added.

After "Persistent Pulmonary Hypertension of the Newborn", "(ICD 9 code 747.83)" was added.

After "Meconium Aspiration Syndrome", "(ICD 9 code 770.1)" was added.

After "Seizures", "(ICD 9 code 779.0)" was added.

A new row was added after "Seizures": "Infections (7 ICD 9 code 771.81)".

After "5 minute Apgar", "<5" was changed to "<7 (exclude infants <500 grams)"

Under table "2" add "**\*If in expanded VON, use VON data for "all babies" categories**".

In the table after "**E. Fetal Deaths**":

"200", "200", and "201" was added in the last three boxes in the first row.

The weights in the boxes after "<500 grams" were changed to "500-749", "750-999", "1000-1249", "1250-1499", "1500-1999", "2000-2499", "2500-2999", "3000-3499", "3500-3999", "4000-4499", "4500-4999" and a new row was added with "5000 – Plus" in the first box

In the table after "**F. Mortality Data**":

"200", "200", and "201" were added in the last three boxes in the first row.

After "(Hospital of Delivery)", "(attach table with individual dispositions, factors and cause of death)" was added; "Pregnancy Related" and "Non-Pregnancy Related" were added on separate lines underneath.

After "Perinatal Deaths", "(attach summary table with dispositions and factors per year for 3 years)" was added.

"(complete attached chart FD)" was deleted and "(complete attached chart ND)" was added; "(FD)" was added after "Fetal Death" and "(ND)" after "Neonatal Death".

The following new rows were added:

"\*3. Mortality Rates (all births)

a. Fetal Mortality Rate (FD/total births X 1000)

b. Neonatal Mortality Rate (ND/total live births X 1000)

c. Perinatal Mortality Rate (FD + ND/total births X 1000)

d. Vermont Oxford Standard Mortality Rate"

Below the table, "\*Question #3, only for Level III institutions" was added.

In the table under "**G Transport Data**":

## DEPARTMENT OF PUBLIC HEALTH

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A new row was added with "200", "200", and "201" in the last three boxes above "1." and above "2."

In "3", the text was changed to read as follows: "Provide maternal and neonatal transport information for the most current calendar year – (for Perinatal Centers, provide transport information by hospital, gestational age and by year for 3 years)."

A new "II" was added as follows:

**"II. OB Hemorrhage Documentation**

List OB Hemorrhage cases from the calendar previous year (Patients sent to ICU or received 3 or greater units of blood products)"

36. In Section 640. Appendix G, IV.A., "one year" was stricken and "three years" was added.

37. In the heading of Appendix H, "**Referral**" was stricken and "**Consultation**" was added.

The following changes were made in response to comments and suggestions of JCAR:

1. In the definition of "Regional Perinatal Network" in Section 640.20, "levels" was stricken.

2. In Section 640.25 (b)(5), "Freedom of Information" was stricken.

3. In Section 640.42(f)(2)(C), "subsection (c)(3)" was changed to "subsections (c)(3)(C) through (L)".

4. In Section 640.42(g)(2)(A), line 1, "A" was stricken and "Effective July, 2011, a" was added.

5. In Section 640.43(c)(8), "A board-certified neonatologist, active candidate neonatologist shall be present and available in the hospital 24 hours a day to provide care for newborns in the NICU." was changed to "Medical director-neonatal: to direct the neonatal portion of the program. Neonatal activities shall be directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of

## DEPARTMENT OF PUBLIC HEALTH

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Pediatricians/Neonatal-Perinatal Medicine. The directors of the neonatal services shall ensure the back-up supervision of their services when they are unavailable."

6. In Section 640.Appendix A, in "2." in the table under "**G. Transport Data**", "/transports" was added after "transfers"; in "3.", "**by**" was added after "**gestational**".

7. In Section 640. Appendix A, in the sentence under "**II. OB Hemorrhage Documentation**", "calendar previous" was changed to "previous calendar".

In addition, various typographical, grammatical, and form changes were made in response to the comments from JCAR.

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Section 640.10 has been repealed because the language is not regulatory and is not needed in the rules. Section 640.20 has been amended to add new definitions that reflect current acceptable standards in medical practice. Section 640.25 has been amended to include current State statutes and rules and association standards that are referenced and incorporated in Part 640. Section 640.30 has been amended to revise the composition and responsibilities of the Perinatal Advisory Committee (PAC). Section 640.40 has been amended to include non-birthing center information, to update the current levels of perinatal care provided in Illinois, and to add a requirement for hospitals to inform the Department of a loss of essential resources. Section 640.41, Section 640.42, and Section 640.43 have been amended to reflect the current accepted language, trends, practices and standards outlined at those levels of care, including continuing education requirements and the content of the letter of agreement with the hospital's Administrative Perinatal Center. Application for Designation requirements are set forth.

Section 640.44 has been amended to reflect changes in the name and the responsibilities of the Administrative Perinatal Center (APC). Section 640.45 has been amended to clarify the Department's responsibility for oversight of the designation process. Section 640.50 has been amended to reflect changes in the Department's designation process. Section 640.60 has been amended to make technical changes in the application process

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

requirements and to add procedural steps for a change in network affiliation. Section 640.70 has been amended to update the requirements for the letter of agreement.

Section 640.80 has been amended to reflect changes in funding for regional perinatal networks. Section 640.85 has been added to place provisions for exceptions in one Section. Section 640.90 has been amended to reflect changes in reporting requirements. Section 640.100 has been amended because the Department of Human Services now manages this program.

Section 640. Appendix A has been amended to promote accuracy and collection of meaningful data and information without redundancy. Section 640. Appendix B and its Exhibits have been repealed because these data are no longer being collected. Section 640, Appendix C and its Exhibits have been repealed because the data collection is not associated with any statistical or follow-up purpose. Section 640. Appendix F and its Exhibits have been repealed. Section 640. Appendix G and Section 640. Appendix H have been amended to reflect the changes in the rules. Section 640. Appendix I has been amended to reflect more current ethnicity and to include new neonatal complications. Section 640. Appendix J and Section 640. Appendix K have been added to delineate to hospitals the steps to be taken and the elements that must be included in the application process for designation, re-designation, or change in designation as it applies to the Perinatal Program. Section 640. Appendix L, Section 640. Appendix M, Section 640. Appendix N, and Section 640. Appendix O have been added to outline areas of focus and to provide a means of describing institutional compliance.

16) Information and questions regarding this rulemaking shall be directed to:

Susan Meister  
Division of Legal Services  
Department of Public Health  
535 West Jefferson, 5<sup>th</sup> Floor  
Springfield, Illinois 62761

e-mail: [dph.rules@illinois.gov](mailto:dph.rules@illinois.gov)  
217/782-2043

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

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH  
 CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
 SUBCHAPTER I: MATERNAL AND CHILDCARE

PART 640  
 REGIONALIZED PERINATAL HEALTH CARE CODE

## Section

640.10	Scope ( <a href="#">Repealed</a> )
640.20	Definitions
640.25	Incorporated <a href="#">and Referenced</a> Materials
640.30	Perinatal Advisory Committee
640.40	Standards for Perinatal Care
640.41	Level I – Standards for Perinatal Care
640.42	Level II and Level II with Extended <a href="#">Neonatal</a> Capabilities – Standards for Perinatal Care
640.43	Level III – Standards for Perinatal Care
640.44	<a href="#">Administrative</a> Perinatal Center
640.45	<a href="#">Department of Public Health Agency</a> -Action
640.50	Designation and Redesignation of <a href="#">Non-Birthing Center</a> , Level I, Level II, Level II with Extended <a href="#">Neonatal</a> Capabilities, <del>and</del> Level III Perinatal <a href="#">Hospitals and Administrative Perinatal Centers</a> <del>Facilities</del>
640.60	<del>Application Information</del> for <a href="#">Hospital Facility</a> Designation <del>and</del> Redesignation as a <a href="#">Non-Birthing Center</a> Level I, Level II, Level II with Extended <a href="#">Neonatal</a> Capabilities, <del>and</del> Level III Perinatal <a href="#">Hospital and Administrative Perinatal Center, Facilities</a> and Assurances Required of Applicants
640.70	Minimum Components for Letters of <del>Agreement</del> <a href="#">Agreements</a> Between <a href="#">Non-Birthing Center</a> , Level I, Level II, Level II with Extended <a href="#">Neonatal</a> Capabilities, or Level III Perinatal <a href="#">Hospitals</a> <del>Facilities</del> and Their <a href="#">Administrative</a> Perinatal Center
640.80	Regional Perinatal Networks – Composition and Funding
<a href="#">640.85</a>	<a href="#">Exceptions to Part 640</a>
640.90	<a href="#">State</a> Perinatal Reporting System
640.100	High-Risk Follow-up Program
640.APPENDIX A	Standardized Perinatal Site Visit Protocol
640.APPENDIX B	Outcome Oriented Data: Perinatal Facility Designation/Redesignation ( <a href="#">Repealed</a> )
640.EXHIBIT A	Outcome Oriented Data Form ( <a href="#">Repealed</a> )
640.EXHIBIT B	Data Collection Exception Form ( <a href="#">Repealed</a> )

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- 640.APPENDIX C Maternal Discharge Record ([Repealed](#))  
 640.EXHIBIT A Maternal Discharge Record Form ([Repealed](#))  
 640.EXHIBIT B Instructions for Completing Maternal Discharge Record ([Repealed](#))
- 640.APPENDIX D Report of Local Health Nurse, Maternal – Prenatal (Repealed)  
 640.EXHIBIT A Local Health Nurse, Maternal – Prenatal Form (Repealed)  
 640.EXHIBIT B Instructions for Completing the Report of Local Health Nurse, Maternal – Prenatal (Repealed)
- 640.APPENDIX E Report of Local Health Nurse, Maternal – Postnatal (Repealed)  
 640.EXHIBIT A Local Health Nurse, Maternal – Postnatal Form (Repealed)  
 640.EXHIBIT B Instruction for Completing the Report of Local Health Nurse, Maternal – Postnatal (Repealed)
- 640.APPENDIX F Report of Local Health Nurse, Infant ([Repealed](#))  
 640.EXHIBIT A Local Health Nurse, Infant Form ([Repealed](#))  
 640.EXHIBIT B Instructions for Completing the Report of Local Health Nurse, Infant ([Repealed](#))
- 640.APPENDIX G Sample Letter of Agreement
- 640.APPENDIX H Written Protocol for [Consultation/Referral/Transfer/Transport](#)  
 640.EXHIBIT A Level I: Patients for consultation with \_\_\_\_\_ (Level III [hospital facility](#) or [Administrative](#) Perinatal Center)  
 640.EXHIBIT B Level II: Patients for consultation with or transfer to \_\_\_\_\_ (Level III [hospital facility](#) or [Administrative](#) Perinatal Center)  
 640.EXHIBIT C Level I: Maternal and ~~neonatal Neonatal~~ patients to be cared for at \_\_\_\_\_ hospital (Level III [hospital facility](#) or [Administrative](#) Perinatal Center)  
 640.EXHIBIT D Level II: Maternal and ~~neonatal Neonatal~~ patients to be cared for at \_\_\_\_\_ hospital (Level III [hospital facility](#) or [Administrative](#) Perinatal Center)
- 640.APPENDIX I Perinatal Reporting System Data Elements  
[640.APPENDIX J Guideline for Application Process for Designation, Redesignation or Change in Designation](#)  
[640.APPENDIX K Elements for Submission for Designation, Redesignation or Change in Designation](#)  
[640.APPENDIX L Level I Resource Checklist](#)  
[640.APPENDIX M Level II Resource Checklist](#)  
[640.APPENDIX N Level II with Extended Neonatal Capabilities Resource Checklist](#)  
[640.APPENDIX O Level III Resource Checklist](#)

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AUTHORITY: Implementing and authorized by the Developmental Disability Prevention Act [410 ILCS 250].

SOURCE: Adopted at 5 Ill. Reg. 6463, effective June 5, 1981; amended at 6 Ill. Reg. 3871, effective March 29, 1982; emergency amendment at 8 Ill. Reg. 882, effective January 5, 1984, for a maximum of 150 days; amended and codified at 8 Ill. Reg. 19493, effective October 1, 1984; amended at 9 Ill. Reg. 2310, effective February 15, 1985; amended at 10 Ill. Reg. 5141, effective April 1, 1986; amended at 11 Ill. Reg. 1584, effective February 1, 1987; Part repealed and new Part adopted at 14 Ill. Reg. 12749, effective October 1, 1990; amended at 24 Ill. Reg. 12574, effective August 4, 2000; amended at 35 Ill. Reg. 2583, effective January 31, 2011.

**Section 640.10 Scope (Repealed)**

~~The "Regionalized Perinatal Health Care Code" is designed to coordinate and facilitate the use of ongoing efforts and existing resources in Illinois to improve perinatal health and to prevent perinatal mortality and conditions leading to developmental disabilities.~~

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.20 Definitions**

"Act" means the Developmental Disability Prevention Act [410 ILCS 250].

"Active Candidate" means having completed a residency in the appropriate medical discipline in a program approved by the Residency Review Committee or a program approved by the Council on Postdoctoral Training (COPT) for the American Osteopathic Association (AOA). Active candidates shall become board certified within five years after completion of an approved program.

"Administrative Perinatal Center" or "APC" means a referral facility intended to care for the high-risk patient before, during, or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services. (Section 2(e) of the Act) An APC is a university or university-affiliated hospital designated by the Department as a Level III hospital, that receives financial support from the Department to provide leadership and oversight of the Regionalized Perinatal Healthcare Program.

"Advanced Practice Nurse" or "APN" means a person who has met the

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qualifications for a certified nurse midwife (CNM); certified nurse practitioner (CNP); certified registered nurse anesthetist (CRNA); or a clinical nurse specialist (CNS) and has been licensed by the Department of Financial and Professional Regulation.

"Affiliated Hospital" means an institution that has a letter of agreement with a specific APC.

"Apgar" means the score devised in 1952 by Virginia Apgar to assess the health of newborn children immediately after birth. The five criteria are Activity (Muscle Tone), Pulse, Grimace (Reflex Irritability), Appearance (Skin Color), and Respiration.

"Assisted Ventilation" means the movement of gas into and out of the lung by an external source connected directly to the patient. The external source may be a resuscitation bag, a continuous distending pressure device, or a mechanical ventilator. Attachment to the patient can be by way of a face mask, a head box, an endotracheal tube, nasal prongs, a tracheostomy, or a negative-pressure apparatus surrounding the thorax.

~~"Bioethical or Infant Care Review Committee" means a hospital-based consultative group consisting of physicians and nonphysicians which can provide education, develop and recommend institutional policies, and offer consultation to providers and families facing a range of ethical problems or questions about the medical treatment of infants.~~

"Certified Local Health Department" means a local health department ~~that~~which receives program approval from the Department for all ten required basic health programs during required program and performance review.

*"Congenital" means those intrauterine factors which influence the growth, development and function of the fetus. (Section 2(b) of the Act)*

"Consultation" means ~~a health care provider~~an attending physician obtaining information from an obstetrician, a maternal-fetal medicine physician or neonatologyneonatology specialist via the telephone, in writing, or in person for the purpose of making patient care decisions and developing a care plan.

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"Continuous Quality Improvement" or "CQI" means a structured organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care that meets or exceeds expectations.

*"Department" means the Department of Public Health. (Section 2(h) of the Act)*

~~"Designated Local Health Agency" means an agency designated by the Department to provide maternal, infant, and family follow-up services to residents of a particular area. In areas served by a Certified Local Health Department, that department is the Designated Local Health Agency. For areas not served by a Certified Local Health Department, the designated Local Health Agency is a Certified Local Health Department for another county which has a contract with the Department to provide maternal, infant, and family follow-up services within the area or a county nurse or community nurse agency which has a contract with the Department to provide maternal, infant, and family follow-up services within the area.~~

"Designation" means official recognition of a hospital ~~facility~~ by the ~~Director of the~~ Department as having met the standards contained in Section 640.40 and Section 640.50 for the level of care that the hospital will provide as a part of a regional perinatal network for all levels of perinatal care.

*"Developmental Disability" means mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions of an individual found to be closely related to mental retardation or to require treatment similar to that required by mentally retarded individuals, and the disability originates before such individual attains age 18, and has continued, or can be expected to continue indefinitely, and constitutes a substantial handicap of such individuals. (Section 2(f) of the Act)*

"Dietitian" means a person who is licensed as a dietitian in accordance with the Dietetic and Nutrition Services Practice Act [225 ILCS 30].

*"Disability" means a condition characterized by temporary or permanent, partial or complete impairment of physical, mental or psychological function. (Section 2(g) of the Act)*

*"Environmental" means those extrauterine factors which influence the adaptation, well being or life of the newborn and may lead to disability. (Section 2(c) of the Act)*

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"Essential Resource" means a component, such as medical or nursing medical staff; a service, such as heat, water, or electrical power, or equipment that is necessary to maintain the designated level of care.

~~"Family Centered Care" means the services of the health team that foster parent-newborn family relationships such as those described in American College of Obstetricians and Gynecologists, Family Center Maternity/Newborn Care in Hospitals, and American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care.~~

"Full-time" means on duty a minimum of 36 hours, four days per week.

"Handicapping Condition" means a medically recognized birth defect that threatens life or has a potential for a developmental disability in accordance with Subpart C of the Illinois Health and Hazardous Substances Registry ~~Code~~ (77 Ill. Adm. Code 840.210).

"Health Care Provider" means an individual who provides medical services or treatments to patients within his or her scope of practice. This may include, but is not limited to, physician, nurse, dietitian, social worker and respiratory care provider.

~~*"High-Risk" means an increased level of risk of harm or mortality to the woman of childbearing age, fetus or newborn from congenital and/or environmental factors. (Section 2(d) of the Act)*~~

"High-Risk Infant" means a live-born infant fitting the Adverse Pregnancy Outcomes Reporting ~~System~~Systems (APORS) case definition. (See 77 Ill. Adm. Code ~~840.200~~840.210.)

~~*"High Risk" means an increased level of risk of harm or mortality to the woman of childbearing age, fetus or newborn from congenital and/or environment factors. (Section 2(d) of the Act)*~~

"Hospital" means a facility defined as a hospital in Section 3 of the Hospital Licensing Act [210 ILCS 85].

"Intermediate Care Nursery" or "ICN" means a nursery that provides nursing care to those infants convalescing or those sick infants not requiring intensive care.

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"Joint Morbidity and Mortality Review" means the required review of maternal and neonatal cases attended by the APC's maternal-fetal medicine physician, neonatologist and the Perinatal Center administrator and/or obstetric and neonatal educators. The review is a quality improvement initiative under the Medical Studies Act [735 ILCS 5/8-2101] and consists of cases presented by the attending physician at the Regional Network Hospital. The review includes all maternal, fetal and neonatal deaths, as well as selected morbidities as determined by the APC's Regional Quality Council or defined in the Regional Network Hospital's letter of agreement. The review provides evaluation and disposition of outcomes to guide educational program needs and quality improvement initiatives.

"Letter of Agreement" means a document executed between the APC and the hospital, which includes responsibilities of each party in regard to the hospital's level of designation and the services to be provided.

"Maternity or Neonatal Complications" means those medically determined high-risk conditions, including, but not limited to, those explained in the Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists.

"Maternity and Neonatal Service Plan" means the description required under Subpart O of the Hospital Licensing Requirements (77 Ill. Adm. Code 250) of the hospital's services for care of maternity and neonatal patients, and the way in which the services are part of an integrated system of perinatal care provided by designated perinatal facilities.

~~"Maternity or Neonatal Complications" means those medically determined high-risk conditions including but not limited to those explained in the Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists.~~

"Morbidity" means an undesired result or complication associated with a pregnancy, whether naturally occurring or as the result of treatment rendered or omitted.

"Neonatal Intensive Care Unit" or "NICU" means an intensive care unit for high risk neonates, directed by a board-certified pediatrician with subspecialty certification in neonatal/perinatal medicine.

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"Neonate" means an infant less than 28 days of age.

"Nurse" means a registered nurse or a licensed practical nurse as defined in the Nurse Practice Act [225 ILCS 65].

"Nurse Midwife, Certified" or "Certified Nurse Midwife" or "CNM" means an individual educated in the two disciplines of nursing and midwifery who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives (ACNM).

*"Perinatal" means the period of time between the conception of an infant and the end of the first month of life. (Section 2(a) of the Act)*

"Perinatal Advisory Committee" or "PAC" means the advisory and planning committee established by the Department, which is referred to in Section 3 of the Act.

~~*"Perinatal Center" means a referral facility intended to care for the high-risk patient before, during or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services. (Section 2(e) of the Act)*~~

"Pharmacist, Registered" or "Registered Pharmacist" means a person who holds a certificate of registration as a registered pharmacist, a local registered pharmacist or a registered assistant pharmacist under the Pharmacy Practice Act of 1987 [225 ILCS 85].

"Physician" means any person licensed to practice medicine in all its branches as defined in the Medical Practice Act of 1987 [225 ILCS 60].

"Preventive Services" means a medical intervention provided to a high risk mother and/or neonate in an effort to reduce morbidity and mortality.

~~*"Reactions, Skills and Abilities for Developmental Screening (RSA)" is an objective observation guide used to conduct developmental screening in children.*~~

~~*"Regional Perinatal Management Group" means an organization of representatives of perinatal services, providers and service related agencies and organizations within a regional perinatal network that is responsible for the planning, development, evaluation and operation of the network and the*~~

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~~establishment of regional priorities and policies for system support activities and staff.~~

"Refer" means to send or direct for treatment.

"Regional Perinatal Network" means any number and combination of hospitals providing hospital-based maternity and newborn services facilities functioning at a designated level ~~one or three levels~~ of perinatal care.

~~"Regional Quality Council" or "RQC" means an organization of representatives of perinatal services, providers and service-related agencies and organizations within a regional perinatal network that is responsible for the planning, development, evaluation and operation of the network and the establishment of regional priorities and policies for system support activities and staff.~~

"Registered Nurse" means a person licensed as a registered professional nurse under the Nurse Practice Act.

"Respiratory Care Practitioner" means a person licensed as a respiratory care practitioner under the Respiratory Care Practice Act [225 ILCS 106].

"Social Worker" means a person who is a licensed social worker or a licensed clinical social worker under the Clinical Social Work and Social Work Practice Act [225 ILCS 20].

"Special Care Nursery" or "SCN" means a nursery that provides intermediate intensive care, directed by a board-certified pediatrician with subspecialty certification in neonatal/perinatal medicine, to infants who weigh more than 1250 grams.

"State Perinatal Reporting System" means any system that requires data collection and submission of data to the Department. These systems include, but are not limited to, birth certificate submission, metabolic newborn screening, newborn hearing screening, perinatal HIV testing, and the Adverse Pregnancy Outcomes Reporting System (APORS) (see 77 Ill. Adm. Code 840).

"Statewide Quality Council" means the standing subcommittee established by the Perinatal Advisory Committee that is responsible for monitoring the quality of care and implementing recommendations for improving the quality of care being

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provided in the perinatal care system.

"Substantial Compliance" means meeting requirements, except for variance from the strict and literal performance that results in unimportant omissions or defects, given the particular circumstances involved.

"Substantial Failure" means the failure to meet requirements, other than unimportant omissions or defects, given the particular circumstances involved.

"Support Services" means the provision of current information regarding the identified handicapping conditions, referrals and counseling services, and the availability of additional consultative services.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.25 Incorporated and Referenced Materials**

The following regulations, standards, ~~and~~ statutes and rules are incorporated or referenced in this Part.

## a) State of Illinois Statutes:

- 1) Developmental Disability Prevention Act [410 ILCS 250]"AN ACT relating to the prevention of developmental disabilities" (Ill. Rev. Stat. 1989, ch. 111½, par. 2101). (See Section 640.20).
- 2) Freedom of Information Act [5 ILCS 140](Ill. Rev. Stat. 1989, ch. 116, par. 201 et seq.). (See Section 640.90 (e)(1) and (3)).
- 3) Illinois Health Statistics Act [410 ILCS 520](Ill. Rev. Stat. 1989, ch. 111½, par. 5601 et seq.). (See Section 640.90(e)(2)).
- 4) Hospital Licensing Act [210 ILCS 85](Ill. Rev. Stat. 1989, ch. 111½, par. 142 et seq.). (See Section 640.90(e)(2)).
- 5) Section 8-2101 of the Code of Civil Procedure (Medical Studies Act) [735 ILCS 5/8-2101](Ill. Rev. Stat. 1989, ch. 110, par. 8-2101). (See Section 640.90(b)(3), (e)(1) and (2)).

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- 6) [State Records Act \[5 ILCS 160\]](#)~~(Ill. Rev. Stat. 1989, ch. 116, par. 43.4 et seq.). (See Section 640.90(e)(1)).~~
  - 7) [Illinois Health and Hazardous Substances Registry Act \[410 ILCS 525\]](#)
  - 8) [Vital Records Act \[410 ILCS 535\]](#)
  - 9) [Respiratory Care Practice Act \[225 ILCS 106\]](#)
  - 10) [Dietetic and Nutrition Services Practice Act \[225 ILCS 30\]](#)
  - 11) [Illinois Administrative Procedure Act \[5 ILCS 100\]](#)
  - 12) [Nurse Practice Act \[225 ILCS 65\]](#)
  - 13) [Pharmacy Practice Act of 1987 \[225 ILCS 85\]](#)
  - 14) [Medical Practice Act of 1987 \[225 ILCS 60\]](#)
  - 15) [Clinical Social Work and Social Work Practice Act \[225 ILCS 20\]](#)
- b) State of Illinois ~~Rules~~[Regulations](#)
- 1) [Department of Public Health – Illinois Health and Hazardous Substances Registry \(77 Ill. Adm. Code 840\)](#)~~– (See Sections 640.20, definition of "Handicapped Condition", 640.41 (e)(3), 640.90 (e)(1)).~~
  - 2) [Department of Public Health – Hospital Licensing Requirements \(77 Ill. Adm. Code 250\)](#)~~– (See Sections 640.20 definition of "Maternity and Neonatal Service Plan", 640.40, 640.41, 640.42, 640.43).~~
  - 3) [Department of Public Health – ~~Rules of~~ Practice and Procedure ~~infor~~ Administrative Hearings \(77 Ill. Adm. Code 100\)](#)~~– (See Section 640.45 (b)).~~
  - 4) [Department of Human Services – Maternal and Child Health Services Code \(77 Ill. Adm. Code 630\)](#)~~– (See Sections 640.80 (b)).~~
  - 5) [Department of Public Health – Access to Public Records of the](#)

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Department of Public Health Freedom of Information (2 Ill. Adm. Code 11271126) ~~(See Section 640.90 (e)(3)).~~

## c) Standards or Guidelines

~~1) Family Center Maternity/Newborn Care in Hospitals, American College of Obstetricians and Gynecologists (1978) (409 12<sup>th</sup> Street, SW, Washington, DC 20024). (See Sections 640.20, definition of "Family Centered Care")~~

~~1)2) Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2007)(1988) (which may be obtained from the American Academy of Pediatrics AAP, 141 Northwest Point Road, P.O. 927, Elk Grove Village, Illinois 60009-092760204). (See Sections 640.20, definition of "Family Centered Care," and "Maternity or Neonatal Complications", and (Section 640.43(d)(2);~~

~~2) Vermont Oxford Network: VLBW (Very Low Birth Weight) Summary for Birth Years 2006-2008 (which may be obtained from the Vermont Oxford Network, 33 Kilburn Street, Burlington, Vermont 05401; www.vtoxford.org)~~

~~3) Fundamental Statistics in Psychology and Education, Guilford and Fruehler (1978) New York McGraw-Hill. (See Section 640.80(b)(3)(E)~~

d) All incorporations by reference of ~~federal regulations and~~ the standards of nationally recognized organizations refer to the ~~regulations and~~ standards on the date specified and do not include any ~~amendments or editions~~~~additions or deletions~~ subsequent to the date specified.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.30 Perinatal Advisory Committee**

- a) The Perinatal Advisory Committee (PAC) is an advisory body to the Department in matters pertaining to the regionalization of perinatal health care. The purpose is to advise the Department on the establishment and implementation of policy.
- b) The duties of the PAC~~Perinatal Advisory Committee~~ shall be to advise the Department on and make recommendations concerning:

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- 1) ~~Health~~ policies and quality of care issues affecting perinatal health care services and implementation of the State's perinatal health care plan;
  - 2) ~~The~~ needs of perinatal health care consumers and providers ~~and consumers~~;
  - 3) ~~Methods~~ to seek a better understanding and wider support of regionalized perinatal health care within the local community;
  - 4) ~~Coordinating~~ and organizing regional networks or systems of perinatal health care;
  - 5) ~~Policies~~ relating to planning, operating and maintaining regional networks or systems of perinatal health care;
  - 6) All proposals for rulemaking ~~all proposed rules~~ affecting the provision of perinatal health care services under the Act; and
  - 7) ~~Hospitals~~ maternity hospitals seeking designation or redesignation as described in Sections 640.40 through 640.70.
- c) The ~~PAC~~ Perinatal Advisory Committee shall consist of 22 members appointed by the Director of the Department and six ex-officio members as follows:
- 1) Members
    - A) ~~10~~ Ten licensed physicians;
    - B) Three hospital administrators;
    - C) Two registered nurses;
    - D) One ~~licensed~~ social worker;
    - E) One ~~registered~~ dietitian;
    - F) One ~~registered~~ respiratory care practitioner ~~therapist~~;

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- G) One health planner;
  - H) Two consumers or representatives of the general public interested in perinatal health care; [and](#)
  - I) One representative of a [certified](#) local health department;
- 2) Ex-Officio Members
- A) [One representative of the Illinois Department of Healthcare and Family Services; ~~One representative of the Perinatal Association of Illinois;~~](#)
  - B) [One representative of the Illinois Department of Human Services; ~~One representative of the Perinatal Centers of Illinois;~~](#)
  - C) One representative of the Consortium of Perinatal Network Administrators;
  - D) One representative of the Chicago Department of Public Health;
  - E) One representative of the Chicago Maternal and Child Health Advisory Committee of the Chicago Department of [Public](#) Health; [and](#)
  - F) One representative of the Genetic and Metabolic Diseases Advisory Committee of the Department.
- d) Physician membership on the [PACPerinatal Advisory Committee](#) shall consist of four obstetrician-gynecologists, to include [a](#) subspecialist in maternal/fetal medicine, four pediatricians, to include [a](#) subspecialist in neonatal/perinatal medicine; and two family practice physicians.
- e) Recommendations for physicians shall be solicited from the Illinois State Medical Society, the Illinois Section of the American College of Obstetricians and Gynecologists, the Illinois Chapter of the American Academy of Pediatrics, and the Illinois Chapter of the American Academy of Family Practice. Recommendations for hospital administrators and [a](#) health planner shall be solicited from the Illinois Hospital Association. Recommendations for nurses

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shall be solicited from the Illinois Nurses Association; the Illinois [Section, Association of Women's Health, Obstetric and Neonatal Nursing \(AWHONN\)](#); ~~the National Association of Neonatal Nurses; Nurses Section of the American College of Obstetricians and Gynecologists,~~ and the American College of Nurse-Midwives. Recommendations for [a](#) social worker, [a](#) dietitian and [a](#) respiratory ~~care practitioner~~[therapist](#) shall be solicited from the Illinois Perinatal Social Work Association, the Illinois Dietetics Association and the Illinois Society of Respiratory Care. Recommendations for [a](#) representative of a [certified](#) local health department shall be solicited from the Illinois Association of Public Health Administrators.

- f) Membership of the [PAC Perinatal Advisory Committee](#) shall be selected to be representative of the levels of perinatal care described in Section 640.40, as well as of the different settings in which perinatal care is provided, both geographic and institutional.
- g) Members of the [PAC Perinatal Advisory Committee](#) shall serve four-year terms. Ex-~~officio~~ ~~Officio~~ members shall have no set term of service. Both members and ex-officio members shall have full voting privileges.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.40 Standards for Perinatal Care**

- a) Levels of Perinatal Care  
~~Within each regional perinatal network there shall be three levels of perinatal care, and within Level II there shall be two categories of perinatal care: Level I or general care; Level II or intermediate care, or Level II with Extended Capabilities; and Level III or intensive care. Hospital licensing requirements~~ [Minimum licensing standards](#) for all [three](#) levels [of care](#) are described in Subpart O of the Hospital Licensing Requirements ~~(77 Ill. Adm. Code 250)~~. All hospitals ~~providing obstetrical and neonatal services~~ shall be designated in accordance with ~~the provisions of~~ this Part and [have](#) a letter of agreement with a designated [APC Perinatal Center](#). (Section 640.70 describes the minimum components for the letter of agreement.)~~.-~~
- 1) [Non-Birthing Center hospitals do not provide perinatal services, but have a functioning emergency department. All licensed general hospitals that operate an emergency department shall have a letter of agreement with an](#)

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APC for referral of perinatal patients, regardless of whether the hospital provides maternity or newborn services. The letter of agreement shall delineate, but is not limited to, guidelines for transfer/transport of perinatal patients to an appropriate perinatal care hospital; telephone numbers for consultation and transfer/transport of perinatal patients; educational needs assessment for emergency department staff, and provision of education programs to maintain necessary perinatal skills.

- 2) Level I hospitals provide care to low-risk pregnant women and newborns, operate general care nurseries and do not operate an NICU or an SCN;
- 3) Level II hospitals provide care to women and newborns at moderate risk, operate intermediate care nurseries and do not operate an NICU or an SCN.
- 4) Level II with Extended Neonatal Capabilities hospitals provide care to women and newborns at moderate risk and do operate an SCN but do not operate an NICU.
- 5) Level III hospitals care for patients requiring increasingly complex care and do operate an NICU.

## b) Perinatal Network

Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities and Level III hospitals facilities shall function within the framework of a regionally integrated system of services, under the leadership of an APC, designed to maximize outcomes and to promote appropriate use of expertise and resources. Prenatal Recognition of high risk conditions, prenatal consultations, referrals, or transfers and recognition of high risk conditions are important to improve outcomes. Regional consultant relationships in maternal-fetal medicine and neonatology neonatology referred to in this Part shall be detailed in the letter of agreement. The hospital shall ensure that staff Staff physicians and consultants are familiar with shall be cognizant of the standards and the guidelines in the letter of agreement.

- c) All hospitals shall inform the Department of any change in or loss of essential resources required by this Part within 30 days after the change and/or loss. The hospital shall then replace the required resource within 90 days. Failure to comply shall result in a review by the Department, with a potential loss of designation.

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- e) Non-Maternity General Hospitals  
All licensed general hospitals that may provide emergent or urgent care shall have a letter of agreement with a Perinatal Center for referral of perinatal patients, regardless of whether they provide maternity or newborn services. The letter of agreement shall delineate but not be limited to: guidelines for transfer/transport of perinatal patients to an appropriate perinatal care facility, telephone numbers for consultation and transfer/transport of perinatal patients, educational needs assessment for Emergency Room staff, and provision of education programs to maintain emergency perinatal skills.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.41 Level I – Standards for Perinatal Care**

Level I: To be designated as Level I, a hospital facility shall apply to the Department as described in Section 640.60 ~~of this Part~~; shall and comply with all the conditions described in Subpart O of the Hospital Licensing Requirements that (77 Ill. Adm. Code 250) which are applicable to the level of care necessary for the patients served; and in addition shall comply with the following provisions (specifies regarding standards of care for both mothers and neonates as well as support services to be provided shall be defined in the hospital's letter of agreement with its Perinatal Center):

- a) Level I – General Provisions
- 1) The Maternity and Neonatal Service Plan of the Level I facility shall include:
- A) A letter of agreement between the hospital facility and its APC Perinatal Center establishing criteria for maternal and neonatal regarding plans for prompt consultation; criteria for maternal and neonatal transports; standards of care of mothers and neonates; and support services to be provided. (Section 640.70 establishes the minimum components for the letter of agreement.); with a maternal-fetal medicine subspecialist or neonatologist specific to high-risk women and those neonates with conditions or developmental disabilities requiring transfer, such as: acute surgical and cardiac difficulties, neonates born with handicapping conditions, managing high-risk pregnancies, genetic counseling,

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~~information, referral and counseling services for families of neonates born with a handicapping condition or for a high-risk mother or her spouse, and~~

B) ~~Continuing~~continuing education of staff in perinatal care; ~~and, including family centered care for neonates with handicapping conditions.~~

C) ~~Participation in the CQI program implemented by the APC. (Section 640.70 describes the minimum components for the letter of agreement.) This agreement must include participation in a Continuous Quality Improvement program as defined by the Department and as designed and implemented by the Perinatal Center.~~

2) The critical considerations in the care of patients anticipating delivery in these hospitals are as follows:

A) ~~The~~the earliest possible detection of the high-risk pregnancy (risk assessment); ~~and~~ consultation with a maternal-fetal medicine subspecialist or neonatologist as specified in the letter of agreement; ~~;~~ and transfer to the appropriate level of care; and

B) ~~The~~the availability of trained personnel and facilities to provide competent emergency obstetric and newborn care. Included in the functions of this hospital facility are the stabilization of patients with unexpected problems, initiation of neonatal and maternal transports, patient and community education, and data collection and evaluation.

3) The Level I hospital shall provide continuing education for medical, nursing, respiratory therapy, and other staff providing general perinatal services, with evidence of a yearly competence assessment appropriate to the patient population served.

4)3) The Level I hospital shall maintain a system of recording patient admissions, discharges, birth weight, outcome, complications, and transports ~~to~~must be maintained and meet the ~~requirement~~requirements to support network CQI~~Continuous Quality Improvement~~ activities described

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~~in the hospital's letter of agreement with the APCAs developed by the Statewide Quality Council and must be consistent with that of the Perinatal Center.~~ The hospital shall comply with the reporting requirements of the State Perinatal Reporting System Adverse Pregnancy Outcomes Reporting System (77 Ill. Adm. Code 840).

## b) Level I – Standards for Maternal Care

- 1) The maternal patient with an uncomplicated current pregnancy and no previous history ~~that suggests~~suggestive of potential difficulties is considered appropriate for Level I ~~hospitals; however, the hospital's letter of agreement shall establish the specific conditions for the Level I hospital facilities.~~
- 2) Other than those maternal patients identified in subsection (b)(1), pregnancies of fewer than 36 weeks gestation constitute potentially high-risk conditions for which the attending health care provider shall consult with a board-certified obstetrician or maternal-fetal medicine subspecialist to determine whether a transport or transfer to a higher level of care is needed. The letter of agreement shall specify policies for consultation and the hospital's obstetric policies and procedures for each of, but not limited to, the pregnancy conditions listed in Section 640. Appendix H. Exhibit A. ~~All maternal patients other than those identified in subsection (b)(1) above constitute potentially high-risk conditions for which consultation with a maternal-fetal medicine subspecialist or neonatologist as specified in the letter of agreement is recommended. Consultation or transfer shall be considered for each of the following conditions:~~
  - A) Previous Pregnancy Problems:
    - i) ~~Premature infant~~
    - ii) ~~Perinatal death or mental retardation~~
    - iii) ~~Isoimmunization~~
    - iv) ~~Difficult deliveries~~
    - v) ~~Congenital malformations~~

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- vi) ~~Mid-trimester loss~~
- B) ~~Current Pregnancy Problems:~~
  - i) ~~Any medical disorder (e.g., diabetes mellitus, hemoglobinopathy, chronic hypertension, heart disease, renal disease)~~
  - ii) ~~Drug addiction~~
  - iii) ~~Multiple gestation~~
  - iv) ~~Intrauterine growth restriction~~
  - v) ~~Preterm labor less than or equal to 36 weeks~~
  - vi) ~~Postdate greater than or equal to 42 weeks~~
  - vii) ~~Third trimester bleeding~~
  - viii) ~~Abnormal genetic evaluation~~
  - ix) ~~Pregnancy induced hypertension~~
- 3) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients identified at risk, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years.
- 4) Hospitals shall provide caesarean section decision-to-incision capabilities within 30 minutes.
- c) Level I – Standards for Neonatal Care
  - 1) Neonatal~~The neonatal~~ patients greater than 36 weeks gestation or greater than 2500 grams without risk factors and infants with physiologic jaundice

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are generally considered appropriate for Level I ~~hospitals~~ facilities; however, the ~~hospital's~~ facilities' letter of agreement ~~shall~~ must establish the specific conditions for Level I ~~hospitals~~ facilities.

- 2) For all neonatal patients other than those identified in subsection (c)(1), consultation with a neonatologist is required to determine whether a transport to a higher level of care is needed. Consultation shall be specified in the letter of agreement and outlined in the hospital's pediatric policies and procedures for conditions including, but not limited to:~~All neonatal patients other than those identified in subsection (c)(1) above constitute neonatal conditions for which a neonatology consultation as specified in the letter of agreement by the attending physician is recommended. Consultation or transfer is recommended for each of the following conditions:~~
- ~~A)~~ Gestational age less than 36 weeks, birth weight less than 2500 grams
  - ~~A)B)~~ Small-for-gestational age (less than 10<sup>th</sup> percentile)
  - ~~B)C)~~ Documented sepsis~~Sepsis~~
  - ~~C)D)~~ Seizures
  - ~~D)E)~~ Congenital heart disease
  - ~~E)F)~~ Multiple congenital anomalies
  - ~~F)G)~~ Apnea
  - ~~G)H)~~ Respiratory distress
  - ~~H)I)~~ Neonatal asphyxia
  - ~~I)J)~~ Handicapping~~Infants identified as having handicapping~~ conditions or developmental disabilities ~~that~~ which threaten life or subsequent development
  - ~~J)K)~~ Severe anemia

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~~K)L)~~ Hyperbilirubinemia, not due to physiologic cause

~~L)M)~~ Polycythemia

~~Specifies regarding consultation or transfer for each of these conditions must be detailed in the letter of agreement.~~

d) Level I – Resource Requirements

The following support services shall be available:

- ~~1)~~ ~~Capability for continuous electronic maternal-fetal monitoring for patients identified at risk with staff knowledgeable in its use and interpretation available with evidence of completion of a yearly competence assessment in electronic fetal monitoring.~~
- ~~1)2)~~ Blood bank technicians shall be on call and available within 30 minutes for performance of routine blood banking procedures.
- ~~2)3)~~ General anesthesia services shall be on call and available within 30 minutes to initiate caesarean sections.
- ~~4)~~ ~~Caesarean-section capability within 30 minutes.~~
- ~~3)5)~~ Radiology services shall be available within 30 minutes ~~notice~~.
- ~~4)6)~~ Clinical laboratory services shall include microtechnique for hematocrit, blood gases, and routine urinalysis within 15 minutes; glucose, blood urea nitrogen (BUN)BUN, creatinine, blood gases, routine urinalysis in 1 hour; complete blood count (CBC)CBC, routine blood chemistries, type, cross, Coombs' test; and bacterial smear within one hour~~6 hours~~; and capability for bacterial culture and sensitivity and viral culture.
- ~~5)7)~~ A physician for the program shall be designated to assume primary responsibility for initiating, supervising and reviewing the plan for management~~management~~ of distressed~~depressed~~ infants, ~~in the delivery room~~. Policies and procedures shall assign responsibility for identification and resuscitation of distressed neonates to individuals~~at least one~~

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~~individual who have completed a nationally recognized neonatal resuscitation program and are~~ both specifically trained and immediately available in the hospital at all times, such as another physician, a nurse with training and experience in neonatal resuscitation, or a ~~licensed~~ respiratory care practitioner. ~~Individuals assigned to perform neonatal resuscitation shall have documented evidence of current completion of a neonatal resuscitation course. It is further recommended that physicians and/or advanced practice nurses who care for newborns have documented evidence of completion of a neonatal resuscitation course.~~

- 8) ~~The Level I facility shall be responsible for provision of continuing education for medical, nursing, respiratory therapy, and other staff providing general perinatal services with evidence of a yearly competence assessment appropriate to the patient population served.~~

e) Application for Designation, Redesignation or Change in Network

- 1) To be designated or to retain designation, a hospital shall submit the required application documents to the Department. For information needed to complete any of the processes, see Section 640.50 (Designation and Redesignation of Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities, Level III Perinatal Hospitals, and Administrative Perinatal Centers) and Section 640.60 (Application for Hospital Designation and Redesignation as Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities, Level III Perinatal Hospital, and Administrative Perinatal Center, and Assurances Required of Applicants).
- 2) The following information shall be submitted to the Department to facilitate the review of the hospital's application for designation or redesignation:
- A) Appendix A (fully completed);
- B) Resource Checklist (fully completed);
- C) A proposed letter of agreement between the hospital and the APC (unsigned);

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- D) The curriculum vitae for all directors of patient care, i.e., obstetrics, neonatal, ancillary medical and nursing.
  - 3) When the information described in subsection (e)(2) is submitted, the Department will review the material for compliance with this Part. This documentation will be the basis for a recommendation for approval or disapproval of the applicant hospital's application for designation.
  - 4) The medical co-directors of the APC (or their designees), the medical directors of obstetrics and maternal and newborn care, and a representative of hospital administration from the applicant hospital shall be present during the PAC's review of the application for designation.
  - 5) The Department will make the final decision and inform the hospital of the official determination regarding designation. The Department's decision will be based upon the recommendation of the PAC and the hospital's compliance with this Part, and may be appealed in accordance with Section 640.45. The Department will consider the following criteria to determine if a hospital is in compliance with this Part:
    - A) Maternity and Neonatal Service Plan (Subpart O of the Hospital Licensing Requirements);
    - B) Proposed letter of agreement between the applicant hospital and its APC in accordance with Section 640.70;
    - C) Appropriate outcome information contained in Appendix A and the Resource Checklist (Appendices L, M, N and O);
    - D) Other documentation that substantiates a hospital's compliance with particular provisions or standards of perinatal care; and
    - E) Recommendation of Department program staff.
- e) Exceptions to Level I Standards of Care
- 1) Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes, and geography in the regional perinatal network. These exceptions are not intended to

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~~circumvent the Level II designation. The applicant facility or the Perinatal Center may seek the advice and consultation of the Department as well as the Perinatal Advisory Committee in regard to the conditions necessary for an exception.~~

- 2) ~~Exceptions to the standards of care of this Part may be granted when the facility requesting an exception demonstrates that the resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level II facility. The resource requirements for these exceptions may be found in Section 640.42(d) for Level II facilities. The proposed exceptions shall be determined by the applicant facility and its Perinatal Center based primarily on outcomes.~~
- 3) ~~If the applicant facility and its Perinatal Center cannot reach agreement on any aspect of the exceptions to the standards of care of this Part, the applicant facility or Perinatal Center shall seek the advice and consultation of the Perinatal Advisory Committee (i.e., subcommittee on facility designation). Any exception to the standards of care of this Part shall be clearly defined in the proposed letter of agreement and approved by the Department before implementing the exceptions or patient care services being requested. The Department shall permit a period of testing or trial (probation) to demonstrate that the applicant facility's resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level II facility.~~
- 4) ~~If a dispute between the applicant facility and its Perinatal Center cannot be resolved after consultation with the Perinatal Advisory Committee (i.e., subcommittee on facility designation), then the applicant facility, the Perinatal Center, or the Perinatal Advisory Committee shall submit the dispute to the Department for settlement. The Department shall review all of the relevant information and documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care and the recommendations of the Perinatal Advisory Committee in deciding or settling a dispute. The Department shall inform the applicant facility, the Perinatal Center and the Perinatal Advisory Committee of its decision or judgment.~~
- 5) ~~The following information shall be submitted to the Perinatal Advisory Committee (i.e., subcommittee on facility designation) to facilitate the~~

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~~review of the applicant facility's application for designation with exceptions to the standards of care of this Part:~~

- ~~A) A proposed letter of agreement (unsigned).~~
- ~~B) The curriculum vitae for all directors of patient care, i.e., OB, neonatal, nursing (OB and neonatal).~~
- ~~C) Appendices A and B (fully completed).~~
- ~~D) A letter from the Perinatal Center that includes the following information:
  - ~~i) List of the exceptions being requested.~~
  - ~~ii) Sufficient data/information to demonstrate that the quality of care (outcomes) of the applicant facility are substantially equivalent to the appropriate standards as outlined in subsection (c) of this Section.~~
  - ~~iii) A description of the monitoring system used when a consultation occurs between the attending physician at the referring hospital and the physician consultant at the Perinatal Center or Level III facility and it is determined that the mother or newborn infant should stay in the community hospital for care.~~
  - ~~iv) A description of any arrangements made between the applicant facility and the Perinatal Center to seek or insure quality improvement.~~~~
- ~~6) When the information described in Section 640.41(e) is submitted to the Perinatal Advisory Committee, it shall review the material for compliance with the Regionalized Perinatal Health Care Code, and shall make a recommendation for approval or disapproval of the applicant facility's application for designation with exceptions to the Department.~~
- ~~7) The medical co-directors of the Perinatal Center (or their designees) and the medical directors of obstetrics and maternal and newborn care and a~~

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~~representative of hospital administration from the applicant facility shall be present during the Perinatal Advisory Committee's review of the applicant facility's application for designation with exceptions.~~

- 8) ~~The Department shall review the submitted materials and any other documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care, including quality of care (outcomes) data/information and the recommendation of the Perinatal Advisory Committee, and shall make a recommendation to the Director of Public Health concerning the approval or disapproval of the applicant facility's application for designation with exceptions.~~
- 9) ~~The Director of Public Health shall make the final decision and inform the facility of the official determination regarding designation with exceptions to the standards of care of this Part. The Director's decision shall be based upon the recommendation of the Perinatal Advisory Committee and the facility's compliance with the Regionalized Perinatal Health Care Code, and may be appealed in accordance with Section 640.45. The Director of Public Health shall consider the following criteria or standards to determine if a facility is in compliance with the Code:~~
- ~~A) Maternity and Neonatal Service Plan (Subpart O of the Illinois Hospital Licensing Requirements).~~
  - ~~B) Proposed letter of agreement between the applicant facility and its Perinatal Center in accordance with the provisions described in Section 640.70.~~
  - ~~C) Appropriate outcome information contained in Appendices A and B.~~
  - ~~D) Other documentation that clearly substantiates a facility's compliance with particular provisions or standards of perinatal care.~~
  - ~~E) Recommendation of Department program staff.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.42 Level II and Level II with Extended Neonatal Capabilities – Standards for Perinatal Care**

~~Level II:~~ To be designated as Level II or Level II with Extended Neonatal Capabilities, a hospital facility shall apply to the Department as described in Section 640.60 of this Part; shall and comply with all of the conditions described in Subpart O of the Hospital Licensing Requirements ~~that (77 Ill. Adm. Code 250) promulgated by the Department which~~ are applicable to the level of care necessary for the patients served; and ~~in addition~~ shall comply with the following provisions (specifics regarding standards of care for both mothers and neonates as well as resource requirements to be provided shall be defined in the hospital's letter of agreement with its APC Perinatal Center):

a) Level II and Level II with Extended Neonatal Capabilities – General Provisions

~~1) A Level II or Level II with Extended Neonatal Capabilities hospital shall; facility is to~~

- 1) Provide~~provide~~ all services outlined for Level I (Section 640.41(a));
- 2) Provide~~as well as~~ diagnosis and treatment of selected high-risk pregnancies and neonatal problems; ~~Both the obstetrical service and the neonatal service must achieve the applicable capability of a Level II or Level II with Extended Capabilities facility for the applicable Level II designation. Further standards for Level II facilities are set out in subsections (b) through (h) with subsections (f) through (h) specifically applying to facilities that are Level II with Extended Capabilities. Included in the functions of this facility are education of allied health professionals and~~
- 3) Accept~~acceptance of~~ selected ~~maternal-fetal and~~ neonatal transports from Level I or other Level II hospitals as identified in the ~~letter~~letters of agreement with the APC Perinatal Center; ~~and. The letters of agreement should include participation in a Continuous Quality Improvement program as defined by the Department and implemented by the Perinatal Center.~~
- 4) 2) Maintain a system for recording patient admissions, discharges, birth weight, outcome, complications; and transports ~~must be maintained and must meet requirements~~ to support network CQI~~Continuous Quality~~

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~~Improvement program~~ activities described in the hospital's letter of agreement with the APC. The hospital shall comply with the reporting requirements of the State Perinatal Reporting System as developed by the Statewide Quality Council. The hospital must comply with the requirements of the Adverse Pregnancy Outcomes Reporting System (77 Ill. Adm. Code 840). For hospitals designated Level II with Extended Capabilities, participation in the Perinatal Reporting System is also required.

## b) Level II – Standards for Maternal Care

- 1) The following maternal patients are considered to be appropriate for management and delivery by the primary physician at Level II ~~hospitals~~facilities without requirement for a maternal-fetal medicine consultation; however, the hospital's letter of agreement shall establish the specific conditions for the Level II hospital:
  - A) Those listed for Level I (~~see~~See Section 640.41(b)(~~1~~));
  - B) Normal current pregnancy although obstetric history may ~~suggest~~be suggestive of potential difficulties;
  - C) Selected medical conditions controlled with medical treatment such as: mild chronic hypertension, thyroid disease, illicit drug use, urinary tract infection, and non-systemic steroid-dependent reactive airway disease;
  - D) Selected obstetric complications that present after 32 weeks gestation, such as: mild pre-eclampsia/pregnancy-induced hypertension, placenta previa, abruptio placenta, premature rupture of membranes or premature labor;
  - E) Other selected obstetric conditions that do not adversely affect maternal health or fetal well-being, such as: normal twin gestation, hyperemesis gravidium, suspected fetal macrosomia, or incompetent cervical os;
  - F) Gestational diabetes, Class A1 (White's criteria).

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- 2) ~~The attending health care provider shall consult~~For the following maternal conditions, consultation with a maternal-fetal medicine subspecialist, as detailed in the ~~letter~~letters of agreement with the APC and outlined in the hospital's obstetric department policies and procedures, for each of, but not limited to, the current pregnancy conditions listed in Section 640. Appendix H. Exhibit B. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine subspecialist. ~~with subsequent management and delivery at the appropriate facility as determined by mutual collaboration is recommended.~~
- A) ~~Current obstetric history suggestive of potential difficulties such as: intrauterine growth restriction, prior neonatal death, two or more previous preterm deliveries less than 34 weeks, a single previous preterm delivery less than 30 weeks, birth of a neonate with serious complications resulting in a handicapping condition, recurrent spontaneous abortion or fetal demise, family history of genetic disease;~~
- B) ~~Active chronic medical problems with known increase in perinatal mortality, such as: cardiovascular disease Class I and Class II, autoimmune disease, reactive airway disease requiring treatment with systemic corticosteroids, seizure disorder, controlled hyperthyroidism on replacement therapy, hypertension controlled on a single medication, idiopathic thrombocytopenia purpura, thromboembolic disease, malignant disease (especially when active), renal disease with functional impairment, human immunodeficiency viral infection (consultation may be with maternal-fetal medicine or infectious disease subspecialist);~~
- C) ~~Selected obstetric complications that present prior to 34 weeks gestation, such as: suspected intrauterine growth restriction, polyhydramnios, oligohydramnios, pre-eclampsia/pregnancy-induced hypertension, congenital viral disease, maternal surgical conditions, suspected fetal abnormality or anomaly, isoimmunization with antibody titers greater than 1:8, antiphospholipid syndrome;~~
- D) ~~Abnormalities of the reproductive tract known to be associated~~

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~~with an increase in preterm delivery, such as uterine anomalies or diethyl stilbesterol exposure;~~

E) ~~Insulin dependent diabetes Class A2 and B or greater (White's criteria).~~

3) ~~For the following maternal conditions, referral to a maternal fetal medicine subspecialist for evaluation shall occur. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal fetal medicine subspecialist:~~

A) ~~Selected chronic medical conditions with a known increase in perinatal mortality, such as: cardiovascular disease with functional impairment (Class III or greater), respiratory failure requiring mechanical ventilation, acute coagulopathy, intractable seizures, coma, sepsis, solid organ transplantation, active autoimmune disease requiring corticosteroid treatment, unstable reactive airway disease, renal disease requiring dialysis or with a serum creatinine concentration greater than 1.5 mg%, active hyperthyroidism, hypertension that is unstable or requires more than one medication to control, severe hemoglobinopathy;~~

B) ~~Selected obstetric complications that present prior to 32 weeks gestation (prior to 30 weeks gestation for Level II with extended capabilities), such as: multiple gestation with more than two fetuses, twin gestation complicated by demise, discordancy, or maldevelopment of one fetus or by fetal fetal transfusion, premature labor unresponsive to first line tocolytics, premature rupture of membranes, medical and obstetrical complications of pregnancy possibly requiring induction of labor or non emergent caesarean section for maternal or fetal indications, such as severe pre-eclampsia;~~

C) ~~Isoimmunization with possible need for intrauterine transfusion;~~

D) ~~Insulin dependent diabetes mellitus Classes C, D, R, F, or H (White's criteria);~~

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~~E) Suspected congenital anomaly or abnormality requiring an invasive fetal procedure, neonatal surgery or postnatal medical intervention to preserve life, such as: fetal hydrops, pleural effusion, ascites, persistent fetal arrhythmia, major organ system malformation-malfunction, or genetic condition.~~

3) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients identified at risk, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic maternal-fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years.

## c) Level II – Standards for Neonatal Care

1) The following neonatal patients are considered appropriate for Level II ~~hospitals~~facilities without a requirement for neonatology consultation:

A) Those listed for Level I: (see Section 640.41 ~~(c)(b)(1)~~);

B) Premature infants at 32 or more weeks gestation who are otherwise well;

~~C)B) Infants with mildMild to moderate respiratory distress (not requiring assistedmechanical ventilation in excess of six6 hours);~~

D)C) Infants with suspectedSuspected neonatal sepsis, hypoglycemia responsive to glucose infusion, and asymptomatic neonates of diabetic mothers; and

~~E)D) InfantsNursery care of infants~~ with a birth weight greater than 1500 grams who are otherwise well.

~~E) Nursery care of premature infants at 32 or more weeks gestation who are otherwise well.~~

2) The attending physician shall consult a neonatologist for~~For~~ the following neonatal conditions. Consultation shall be specified,~~neonatology consultation is recommended, as detailed~~ in the letter of agreement with

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the APC and outlined in the hospital's pediatric department policies and procedures for conditions including, but not limited to;~~for each of the following:~~

A) ~~Premature birth with gestation less than 32 weeks, but greater than or equal to 30 weeks;~~

A)B) Birth~~Infants with a birth~~ weight less than 1500 grams,~~but greater than 1250 grams;~~

B)C) Infants with 10 minute Apgar scores of 5 or less;

C)D) Handicapping~~Stable infants identified as having handicapping~~ conditions or developmental disabilities that threaten subsequent development in an otherwise stable infant.

3) Minimum conditions for transport shall be specified in the letter of agreement and outlined in the hospital's pediatric department policies and procedures for conditions including, but not limited to:~~Transfer shall occur upon recommendation of the Perinatal Center for each of the following neonatal conditions:~~

A) Premature birth that is less than 32~~30~~ weeks gestation;

B) Birth weight~~Birthweight~~ less than ~~or equal to 1500~~1250 grams;

C) Assisted~~Infants requiring mechanical~~ ventilation beyond the initial stabilization period of six~~6~~ hours;

D) Infants who require a sustained inhaled oxygen concentration in excess of 50% in order to maintain a transtentaneous or arterial oxygen saturation greater than or equal to 92%;

D)E) Congenital~~Infants with significant congenital~~ heart disease associated with cyanosis, congestive heart failure; or impaired peripheral blood flow;

E)F) Major congenital~~Infants with major congenital~~ malformations requiring immediate comprehensive evaluation or neonatal

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surgery;

~~F)G)~~ ~~Neonatal~~~~Infants requiring neonatal~~ surgery ~~requiring~~~~with~~ general anesthesia;

~~G)H)~~ ~~Sepsis~~~~Infants with sepsis~~, unresponsive to therapy, associated with persistent shock or other organ system failure;

~~H)I)~~ ~~Uncontrolled~~~~Infants with uncontrolled~~ seizures;

~~I)J)~~ ~~Stupor~~~~Infants with stupor~~, coma, hypoxic ischemic encephalopathy Stage II or greater;

~~J)K)~~ ~~Double-volume~~~~Infants requiring double-volume~~ exchange transfusion;

~~K)L)~~ ~~Metabolic~~~~Infants with metabolic~~ derangement persisting after initial correction therapy;

~~L)M)~~ ~~Handicapping~~~~Infants identified as having handicapping~~ conditions that threaten life for which transfer can improve outcome.

d) Level II – Resource Requirements

Resources shall include all those listed for Level I (Section 640.41(d)) as well as the following:

- 1) Experienced blood bank technicians shall be immediately available in the hospital for blood banking procedures and identification of irregular antibodies. Blood component therapy shall be readily available.
- 2) Experienced radiology technicians shall be immediately available in the hospital with professional interpretation available 24 hours a day. Ultrasound capability shall be available 24 hours a day. In addition, Level I ultrasound and staff knowledgeable in its use and interpretation shall be available 24 hours a day.
- 3) Clinical laboratory services shall include microtechnique blood gases in 15 minutes; and electrolytes and coagulation studies within one~~an~~ hour.

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- 4) Personnel skilled in phlebotomy and intravenous (IV)~~I.V.~~ placement in the newborn shall be available 24 hours a day.
- ~~5)~~4) Social work services provided by one ~~licensed medical~~ social worker, ~~preferably~~ with relevant experience and responsibility for perinatal patients, shall be available through the hospital social work department.
- ~~6)~~5) Protocols for discharge planning, routine follow-up care, and developmental follow-up ~~shall~~must be established.
- 6) ~~General anesthesia on call available within 30 minutes to initiate caesarean section.~~
- 7) A ~~licensed~~ respiratory care practitioner with experience in neonatal care shall be available.
- 8) One ~~registered~~ dietitian with experience in perinatal nutrition shall be available to plan diets to meet the needs of mothers and infants.
- 9) Capability to provide neonatal resuscitation in the delivery room shall be satisfied by current completion of a nationally recognized neonatal resuscitation program by medical, nursing and respiratory care staff or a hospital rapid response team. Continuous electronic maternal-fetal monitoring and staff knowledgeable in its use and interpretation, with evidence of completion of a yearly competence assessment in electronic fetal monitoring, shall be available 24 hours a day.
- 10) ~~The Level II facility shall be responsible for provision of continuing education for medical, nursing, respiratory therapy and other staff providing general perinatal services with evidence of a yearly competence assessment appropriate to the patient population served.~~
- 11) ~~A physician for the program shall be designated to assume primary responsibility for initiating, supervising and reviewing the plan for management of depressed infants in the delivery room. Policies and procedures shall assign responsibility for identification and resuscitation of distressed neonates to an individual who is both specifically trained and available in the hospital at all times, such as another physician, a nurse with training and experience in perinatal care, or respiratory therapist.~~

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~~Individuals assigned to perform neonatal resuscitation shall have documented evidence of current completion of a neonatal resuscitation course. It is further recommended that physicians and/or advanced practice nurses who care for newborns have documented evidence of a neonatal resuscitation course.~~

- e) Application for Designation, Redesignation or Change in Network
- 1) To be designated or to retain designation, a hospital shall submit the required application documents to the Department. For information needed to complete any of the processes, see Section 640.50 and Section 640.60.
  - 2) The following information shall be submitted to the Department to facilitate the review of the hospital's application for designation or redesignation:
    - A) Appendix A (fully completed);
    - B) Resource Checklist (fully completed) (Appendices L, M, N and O);
    - C) A proposed letter of agreement between the hospital and the APC (unsigned); and
    - D) The curriculum vitae for all directors of patient care, i.e., obstetrics, neonatal, ancillary medical care and nursing (both obstetrics and neonatal).
  - 3) When the information described in subsection (e)(2) is submitted, the Department will review the material for compliance with this Part. This documentation will be the basis for a recommendation for approval or disapproval of the applicant hospital's application for designation.
  - 4) The medical co-directors of the APC (or their designees), the medical directors of obstetrics and maternal and newborn care, and a representative of hospital administration from the applicant hospital shall be present during the PAC's review of the application for designation.

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- 5) The Department will make the final decision and inform the hospital of the official determination regarding designation. The Department's decision will be based upon the recommendation of the PAC and the hospital's compliance with this Part and may be appealed in accordance with Section 640.45. The Department will consider the following criteria or standards to determine if a hospital is in compliance with this Part:
- A) Maternity and Neonatal Service Plan (Subpart O of the Hospital Licensing Requirements);
  - B) Proposed letter of agreement between the applicant hospital and its APC, in accordance with Section 640.70;
  - C) Appropriate outcome information contained in Appendix A and the Resource Checklist;
  - D) Other documentation that substantiates a hospital's compliance with particular provisions or standards of perinatal care set forth in this Part; and
  - E) Recommendation of Department program staff.
- e) Exceptions to Level II—Standards of Care
- 1) Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes, and geography in the regional perinatal network. These exceptions are not intended to circumvent the Level II with Extended Capabilities designation. The applicant facility or the Perinatal Center may seek the advice and consultation of the Department as well as the Perinatal Advisory Committee in regard to the conditions necessary for an exception.
  - 2) Exceptions to the standards of care of this Part may be granted when the facility requesting an exception demonstrates that the resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level II facility with Extended Capabilities. The resource requirements for these exceptions may be found in subsection (d) of this Section for Level II with Extended Capabilities standards. The proposed exceptions shall be determined by the applicant facility and its

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~~Perinatal Center based primarily on outcomes.~~

- 3) ~~If the applicant facility and its Perinatal Center cannot reach agreement on any aspect of the exceptions to the standards of care of this Part, the applicant facility or Perinatal Center shall seek the advice and consultation of the Perinatal Advisory Committee (i.e., subcommittee on facility designation). Any exception to the standards of care of this Part shall be clearly defined in the proposed letter of agreement and approved by the Department before implementing the exceptions or patient care services being requested. The Department shall permit a period of testing or trial (probation) to demonstrate that the applicant facility's resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level II with Extended Capabilities facility.~~
- 4) ~~If a dispute between the applicant facility and its Perinatal Center cannot be resolved after consultation with the Perinatal Advisory Committee (i.e., subcommittee on facility designation), then the applicant facility, the Perinatal Center or the Perinatal Advisory Committee shall submit the dispute to the Department for settlement. The Department shall review all of the relevant information and documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care and the recommendations of the Perinatal Advisory Committee in deciding or settling a dispute. The Department shall inform the applicant facility, the Perinatal Center and the Perinatal Advisory Committee of its decision or judgment.~~
- 5) ~~The following information shall be submitted to the Perinatal Advisory Committee (i.e., subcommittee on facility designation) to facilitate the review of the applicant facility's application for designation with exceptions to the standards of care of this Part:~~
  - A) ~~A proposed letter of agreement (unsigned).~~
  - B) ~~The curriculum vitae for all directors of patient care, i.e., OB, neonatal, nursing (OB and neonatal).~~
  - C) ~~Appendices A and B (fully completed).~~
  - D) ~~A letter from the Perinatal Center that includes the following~~

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~~information:~~

- ~~i) List of the exceptions being requested.~~
  - ~~ii) Sufficient data/information to demonstrate that the quality of care (outcomes) of the applicant facility are substantially equivalent to the appropriate standards as outlined in subsection (c) of this Section.~~
  - ~~iii) A description of the monitoring system used when a consultation occurs between the attending physician at the referring hospital and the physician consultant at the Perinatal Center or Level III facility and it is determined that the mother or newborn infant should stay in the community hospital for care.~~
  - ~~iv) A description of any arrangements made between the applicant facility and the Perinatal Center to seek or insure quality improvement.~~
- ~~6) When the information described in subsection (c) is submitted to the Perinatal Advisory Committee, it shall review the material for compliance with the Regionalized Perinatal Health Care Code, and shall make a recommendation for approval or disapproval of the applicant facility's application for designation with exceptions to the Department.~~
  - ~~7) The medical co-directors of the Perinatal Center (or their designees) and the medical directors of OB and neonatology and a representative of hospital administration from the applicant facility shall be present during the Perinatal Advisory Committee's review of the applicant facility's application for designation with exceptions.~~
  - ~~8) The Department shall review the submitted materials and any other documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care, including quality of care (outcomes) information and the recommendation of the Perinatal Advisory Committee, and shall make a recommendation to the Director of Public Health concerning the approval or disapproval of the applicant facility's application for designation with exceptions.~~

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- 9) ~~The Director of Public Health shall make the final decision and inform the facility of the official determination regarding designation with exceptions to the standards of care of this Part. The Director's decision shall be based upon the recommendation of the Perinatal Advisory Committee and the facility's compliance with the Regionalized Perinatal Health Care Code, and may be appealed in accordance with Section 640.45. The Director of Public Health shall consider the following criteria or standards to determine if a facility is in compliance with the Code:~~
- ~~A) **Maternity and Neonatal Service Plan (Subpart O of the Illinois Hospital Licensing Requirements).**~~
  - ~~B) Proposed letter of agreement between the applicant facility and its Perinatal Center in accordance with the provisions described in Section 640.70.~~
  - ~~C) Appropriate outcome information contained in Appendices A and B.~~
  - ~~D) Other documentation that clearly substantiates a facility's compliance with particular provisions or standards of perinatal care.~~
  - ~~E) Recommendation of Department program staff.~~
- f) Level II with Extended Neonatal Capabilities – Standards for Special Care Nursery~~Neonatal Intensive Care~~ Services
- 1) The following patients are considered appropriate for Level II with Extended Neonatal Capabilities hospitals~~facilities~~ with SCN~~neonatal intensive care~~ services:
- A) Those listed in subsection (c) of this Section~~for Level II care~~;
  - B) Infants with Nursery care of low birth weight infants greater than 1250 grams;
  - C) Premature~~Nursery care of premature~~ infants of 30 or more

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~~weeks~~ weeks gestation;

D) Infants on ~~assisted~~ mechanical ventilation.

2) For each of the following neonatal conditions, ~~a~~ consultation ~~shall occur~~ between the Level II with Extended Neonatal Capabilities attending physician and the ~~APC Perinatal Center~~ or Level III neonatologist ~~is required~~. ~~The~~ It is expected that the attending neonatologist at the Level II with Extended Neonatal Capabilities ~~hospital facility~~ and the attending neonatologist at the ~~APC Perinatal Center~~ or Level III ~~hospital facility~~ shall determine, by mutual collaboration, the most appropriate hospital facility to continue patient care ~~by mutual collaboration~~. The Level II ~~hospital facility~~ with Extended Neonatal Capabilities shall develop a prospective plan for patient care for those infants who remain at the ~~Level II hospital facility with Extended Capabilities~~. Both the letter of agreement with the APC and the hospital's department of pediatrics' policies and procedures shall identify conditions that might require transfer to a Level III hospital, including, but not limited to: ~~The plan shall include the following criteria that would trigger subsequent transfer to a Perinatal Center or Level III facility:~~

A) Premature birth that is less than 30 weeks gestation;

B) Birth weight less than or equal to 1250 grams;

C) Conditions listed in subsections (c)(3)(C) through (L) of this Section. Infants with significant congenital heart disease associated with cyanosis, congestive heart failure, or impaired peripheral blood flow;

~~D) Infants with major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery;~~

~~E) Infants requiring neonatal surgery with general anesthesia;~~

~~F) Infants with sepsis, unresponsive to therapy, associated with persistent shock or other organ system failure;~~

~~G) Infants with uncontrolled seizures;~~

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- H) ~~Infants with stupor, coma, hypoxic ischemic encephalopathy Stage II or greater;~~
- I) ~~Infants requiring double volume exchange transfusion;~~
- J) ~~Infants with metabolic derangement persisting after initial correction therapy;~~
- K) ~~Infants identified as having handicapping conditions that threaten life for which transfer can improve outcome.~~

g) Level II with Extended Neonatal Capabilities – Resource Requirements

- 1) Resources shall include all those listed in Section 640.41(d) for Level I care and in Section 640.42(d) for Level II care, as well as the following:
  - A) Obstetric activities shall be directed and supervised by a full-time board-certified obstetrician ~~or a subspecialty obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of maternal and fetal medicine~~ or a licensed osteopathic physician with equivalent training and experience and certification~~certified~~ by the American Osteopathic Board of Obstetricians and Gynecologists.
  - B) Neonatal activities shall be directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal Medicine or ana-licensed osteopathic physician with equivalent training and experience and certification~~certified~~ by the American Osteopathic Board of Pediatricians.
  - C) The directors of obstetric and neonatal services shall ensure the back-up supervision of their services when they are unavailable.
  - D) The obstetric-newborn nursing services shall be directed by a full-time nurse experienced in perinatal nursing, preferably with a master's degree.

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- E) The pediatric-neonatal respiratory therapy services shall be directed by a full-time ~~licensed~~ respiratory care practitioner with at least ~~three~~ years experience in all aspects of pediatric and neonatal respiratory therapy, ~~preferably~~ with a bachelor's degree and ~~one successful~~ completion of the neonatal/pediatric specialty examination of the National Board for Respiratory Care.
- F) Preventive services shall be designated to prevent, detect, diagnose and refer or treat conditions known to occur in the high risk newborn, such as: cerebral hemorrhage, visual defects (retinopathy of prematurity), and hearing loss, and to provide appropriate immunization of high-risk newborns.
- G) A ~~designated~~ person shall be designated to coordinate the local health department community nursing follow-up referral process, to direct discharge planning, to make home care arrangements, to track discharged patients, and to collect outcome information. The community nursing referral process shall consist of notifying the high-risk infant follow-up nurse in whose jurisdiction the patient resides. The Illinois Department of Human Services will identify and update referral resources for the area served by the unit.
- H) Each Level II hospital with Extended Neonatal Capabilities shall develop, with the help of the APC, Develop a referral agreement with a neonatal follow-up clinic to provide neuro-developmental assessment and outcome data on the neonatal population. Hospital/Institutional policies and procedures shall will describe the at-risk population and referral procedure to be followed. Infants will be scheduled to be seen at regular intervals. Neurodevelopmental assessments will be communicated to the primary care physicians. Referrals will be made for interventional care in order to minimize neurologic sequelae. A system shall be established to track, record, and report neurodevelopmental outcome for the population, as required to support network CQI activities as developed by the Statewide Quality Council.
- I) If the Level II hospital facility with Extended Neonatal Capabilities transports neonatal patients, the hospital shall comply they must

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~~comply~~ with [Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists](#) ~~the Level III transport resource requirements delineated in Section 640.43(e).~~

- 2) To provide for ~~assisted~~mechanical ventilation of newborn infants beyond immediate stabilization, the Level II ~~hospital facility~~ with Extended Neonatal Capabilities shall also provide the following:
- A) ~~Effective July 1, 2011, a~~A ~~pediatrician~~physician or advanced practice nurse whose professional staff privileges granted by the hospital specifically include the management of critically ill infants and newborns receiving assisted ventilation; or an active candidate or board-certified neonatologist shall be in the hospital the entire time the infant is receiving assisted ventilation. If infants are receiving on-site assisted ventilation care from an advanced practice nurse or a physician who is not a neonatologist, an active candidate or board-certified neonatologist shall be available on call to assist in the care of those infants as needed. experienced in the management of mechanically ventilated infants present in the hospital during the entire time that the infant receives mechanical ventilation.
- B) Suitable ~~backup~~back-up systems and plans shall be in place ~~planning~~ to prevent and respond appropriately to sudden power outage, oxygen system failure, and interruption of medical grade compressed air delivery.
- C) Nurses caring for ~~mechanically ventilated~~ infants who are receiving assisted ventilation shall have documented competence and experience in the care of ~~those mechanically ventilated~~ infants.
- D) A ~~licensed~~ respiratory care practitioner with documented competence and experience in the care of ~~mechanically ventilated~~ infants who are receiving assisted ventilation shall ~~must~~ also be available to the nursery during the entire time that the infant receives ~~assisted~~mechanical ventilation.

h) Application for Designation, Redesignation or Change in Network

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- 1) To be designated or to retain designation, a hospital shall submit the required application documents to the Department. For information needed to complete any of the processes, see Section 640.50 and Section 640.60.
- 2) The following information shall be submitted to the Department to facilitate the review of the hospital's application for designation or redesignation:
  - A) Appendix A (fully completed);
  - B) Resource Checklist (fully completed) (Appendices L, M, N and O);
  - C) A proposed letter of agreement between the hospital and the APC (unsigned); and
  - D) The curriculum vitae for all directors of patient care, i.e., obstetrics, neonatal, ancillary medical, and nursing (both obstetrics and neonatal).
- 3) When the information described in subsection (h)(2) is submitted, the Department will review the material for compliance with this Part. This documentation will be the basis for a recommendation for approval or disapproval of the applicant hospital's application for designation.
- 4) The medical co-directors of the APC (or their designees), the medical directors of obstetrics and maternal and newborn care, and a representative of hospital administration from the applicant hospital shall be present during the PAC's review of the application for designation.
- 5) The Department will make the final decision and inform the hospital of the official determination regarding designation. The Department's decision will be based upon the recommendation of the PAC and the hospital's compliance with this Part, and may be appealed in accordance with Section 640.45. The Department shall consider the following criteria or standards to determine if a hospital is in compliance with this Part:

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- A) Maternity and Neonatal Service Plan (Subpart O of the Hospital Licensing Requirements);
  - B) Proposed letter of agreement between the applicant hospital and its APC in accordance with Section 640.70;
  - C) Appropriate outcome information contained in Appendix A and the Resource Checklist;
  - D) Other documentation that substantiates a hospital's compliance with particular provisions or standards of perinatal care set forth in this Part; and
  - E) Recommendation of Department program staff.
- h) Exceptions to Level II with Extended Capabilities—Standards of Care
- 1) Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes and geography in the regional perinatal network. These exceptions are not intended to circumvent the Level III designation. The applicant facility or the Perinatal Center may seek the advice and consultation of the Department as well as the Perinatal Advisory Committee in regard to the conditions necessary for an exception.
  - 2) Facilities may request an exception to care for some subgroup of neonates listed in subsection (e)(2). The exceptions to the standards of care of this Part may be granted when the facility requesting an exception demonstrates that the resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Perinatal Center or Level III facility. The resource requirements for these exceptions may be found in Section 640.43(e) for Level III. The proposed exceptions shall be determined by the applicant facility and its Perinatal Center based primarily on outcomes.
  - 3) If the applicant facility and its Perinatal Center cannot reach agreement on any aspect of the exceptions to the standards of care of this Part, the applicant facility or Perinatal Center shall seek the advice and consultation of the Perinatal Advisory Committee (i.e., subcommittee on facility

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~~designation) to settle the dispute. Any exception to the standards of care of this Part shall be clearly defined in the proposed letter of agreement and approved by the Department before implementing the exceptions or patient care services being requested. The Department shall permit a period of testing or trial (probation) to demonstrate that the applicant facility's resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Perinatal Center or Level III facility.~~

- 4) ~~If a dispute between the applicant facility and its Perinatal Center cannot be resolved after consultation with the Perinatal Advisory Committee (i.e., subcommittee on facility designation), then the applicant facility, the Perinatal Center or the Perinatal Advisory Committee shall submit the dispute to the Department for settlement. The Department shall review all of the relevant information and documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care and the recommendations of the Perinatal Advisory Committee in deciding or settling a dispute. The Department shall inform the applicant facility, the Perinatal Center and the Perinatal Advisory Committee of its decision or judgment.~~
  
- 5) ~~The following information shall be submitted to the Perinatal Advisory Committee (i.e., subcommittee on facility designation) to facilitate the review of the applicant facility's application for designation with exceptions to the standards of care of this Part:~~
  - A) ~~A proposed letter of agreement (unsigned).~~
  - B) ~~The curriculum vitae for all directors of patient care, i.e., OB, neonatal, nursing (OB and neonatal).~~
  - C) ~~Appendices A and B (fully completed).~~
  - D) ~~A letter from the Perinatal Center that includes the following information:~~
    - i) ~~List of the exceptions being requested.~~
    - ii) ~~Sufficient information to demonstrate that the quality of~~

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~~care (outcomes) of the applicant facility are substantially equivalent to the appropriate standards as outlined in subsection (c) of this Section.~~

- ~~iii) A description of the monitoring system used when a consultation occurs between the attending physician at the referring hospital and the physician consultant at the Perinatal Center or Level III facility and it is determined that the mother or newborn infant should stay in the community hospital for care.~~
  - ~~iv) A description of any arrangements made between the applicant facility and the Perinatal Center to seek or insure quality improvement.~~
- 6) When the information described in subsection (c) is submitted to the Perinatal Advisory Committee, it shall review the material for compliance with the Regionalized Perinatal Health Care Code, and shall make a recommendation for approval or disapproval of the applicant facility's application for designation with exceptions to the Department.
  - 7) The medical co-directors of the Perinatal Center (or their designees) and the medical directors of OB and neonatology and a representative of hospital administration from the applicant facility shall be present during the Perinatal Advisory Committee's review of the applicant facility's application for designation with exceptions.
  - 8) The Department shall review the submitted materials and any other documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care, including quality of care (outcomes) information, and the recommendation of the Perinatal Advisory Committee, and shall make a recommendation to the Director of Public Health concerning the approval or disapproval of the applicant facility's application for designation with exceptions.
  - 9) The Director of Public Health shall make the final decision and inform the facility of the official determination regarding designation with exceptions to the standards of care of this Part. The Director's decision shall be based upon the recommendation of the Perinatal Advisory Committee and the

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~~facility's compliance with the Regionalized Perinatal Health Care Code, and may be appealed in accordance with Section 640.45. The Director of Public Health shall consider the following criteria or standards to determine if a facility is in compliance with the Code:~~

- ~~A) Maternity and Neonatal Service Plan (Subpart O of the Illinois Hospital Licensing Requirements).~~
- ~~B) Proposed letter of agreement between the applicant facility and its Perinatal Center under the provisions described in Section 640.70.~~
- ~~C) Appropriate outcome information contained in Appendices A and B.~~
- ~~D) Other documentation that clearly substantiates a facility's compliance with particular provisions or standards of perinatal care.~~
- ~~E) Recommendation of Department program staff.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.43 Level III – Standards for Perinatal Care**

~~Level III:~~ To be designated as Level III, a hospital facility shall apply to the Department for designation; ~~and shall comply with all of the conditions prescribed in this Part described for intensive (Level III) perinatal care; of this Part and shall comply with all of the conditions prescribed described in Subpart O of the Hospital Licensing Requirements (77 Ill. Adm. Code 250) promulgated by the Department which are~~ applicable to the level of care necessary for the patients served; ~~and in addition shall comply with the following provisions (specifics regarding standards of care for both mothers and neonates as well as resource requirements to be provided shall be defined in the hospital's letter of agreement with its APC their Perinatal Center):~~

- a) Level III – General Provisions
  - 1) A Level III hospital facility shall provide all services outlined for Level I and II (Sections 640.41(a) and 640.42(a)), general, intermediate and special intensive care, as well as diagnosis and treatment of high-risk pregnancy and neonatal problems. Both the obstetrical and neonatal

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services ~~shall~~must achieve Level III capability for Level III designation. ~~The hospital shall and must~~ provide for the education of allied health professionals and ~~shall accept~~acceptance of selected maternal-~~fetal~~ and neonatal transports from Level I, ~~or Level II~~ and Level II with Extended Neonatal Capabilities hospitals facilities.

- 2) The Level III ~~hospital~~facility shall make available a range of technical and subspecialty consultative support such as pediatric anesthesiology, ophthalmology, pediatric surgery, genetic services, intensive cardiac services and intensive neurosurgical services.
- 3) To qualify as a Level III ~~hospital~~facility, these standards and resource requirements are necessary to ensure adequate competence in the management of certain high-risk patients. These criteria will be assessed by reviewing the resources and outcomes of each ~~hospital's~~facility's admissions, and which admissions include patients who are subsequently transferred, for the ~~three~~2 most recent calendar years, combined, for which data are available. ~~The facility must demonstrate an adequate patient base to achieve an NICU average daily census to maintain the resources, expertise, and outcomes required.~~
- 4) A Level III ~~hospital~~facility that elects not to provide all of ~~the advanced level~~these services shall have established policies and procedures for transfer of these ~~mothers and~~ infants to a ~~hospital~~facility that can provide the service needed.
- 5) ~~Perinatal outcome statistics for the Level III facility must be substantially equivalent to those of the Perinatal Center and other designated Level III facilities.~~
- 6) ~~This agreement should include participation in a CQI program as defined by the Department and implemented by the Perinatal Center.~~
- 5)7) ~~The Level III hospital shall maintain a~~A system for recording patient admissions, discharges, birth weight, outcome, complications, and transports ~~to~~must be maintained and must meet requirements to support network CQI activities ~~described in the hospital's letter of agreement with the APC as developed by the Statewide Quality Council.~~ The hospital ~~shall~~must comply with the reporting requirements of the State Perinatal

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~~Reporting System. Adverse Pregnancy Outcomes Reporting System (77 Ill. Adm. Code 840).~~

## b) Level III – Standards of Care

- 1) The Level III hospital facility shall have a policy requiring general obstetricians and newborn care physicians to obtain consultations from or transfer care to the appropriate subspecialists as outlined in the standards for Level II.
- 2) The Level III hospital shall accept all medically eligible Illinois residents. Medical eligibility is to be determined by the obstetric or neonatal director or his/her designee based on the Criteria for High-Risk Identification (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists).
- 3) The Level III hospital shall provide or facilitate emergency transportation of patients referred to the hospital in accordance with guidelines for inter-hospital care of the perinatal patient (Guidelines for Perinatal Care)). If the Level III hospital is unable to accept the patient referred, the APC Level III hospital shall arrange for placement at another Level III hospital or appropriate Level II or Level II hospital with Extended Neonatal Capabilities.
- 4) The Level III hospital shall have a clearly identifiable telephone number, facsimile number or other electronic communication, either a special number or a specific extension answered by unit personnel, for receiving consultation requests and requests for admissions. This number shall be kept current with the Department and with the Regional Perinatal Network.
- 5) The Level III hospital shall provide and document continuing education for medical, nursing, respiratory therapy, and other staff providing general, intermediate and intensive care perinatal services.
- 6) The Level III hospital shall provide caesarean section decision-to-incision capabilities within 30 minutes.

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- 7) The Level III hospital shall provide data relating to its activities and shall comply with the requirements of the State Perinatal Reporting System.
- 8) The medical co-directors of the Level III hospital shall be responsible for developing a system ensuring adequate physician-to-physician communication. Communication with referring physicians of patients admitted shall be sufficient to report patient progress before and at the time of discharge.
- 9) Hospitals shall have the capability for continuous electronic maternal-fetal monitoring for patients identified at risk, with staff available 24 hours a day, including physician and nursing, who are knowledgeable of electronic maternal-fetal monitoring use and interpretation. Physicians and nurses shall complete a competence assessment in electronic maternal-fetal monitoring every two years.
- 10) The Level III hospital, in collaboration with the APC, shall establish policies and procedures for the return transfer of high-risk mothers and infants to the referring hospital when they no longer require the specialized care and services of the Level III hospital.
- 11) The Level III hospital shall provide backup systems and plans shall be in place to prevent and respond to sudden power outage, oxygen system failure and interruption of medical grade compressed air delivery.
- 12) The Level III hospital shall provide or develop a referral agreement with a developmental follow-up clinic to provide neuro-developmental services for the neonatal population. Hospital policies and procedures shall describe the at-risk population and the referral procedure to be followed for enrolling the infant in developmental follow-up. Infants shall be scheduled for assessments at regular intervals. Neuro-developmental assessments shall be communicated to the primary care physicians. Referrals shall be made for interventional care in order to minimize neurologic sequelae. A system shall be established to track, record and report neuro-developmental outcome data for the population, as required to support network COI activities.
- 13) Neonatal surgical services shall be available 24 hours a day.

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## c) Level III – Resource Requirements

- 1) Obstetric activities shall be directed and supervised by a full-time subspecialty obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of Maternal and Fetal Medicine, or an osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Obstetricians and Gynecologists. The director of the obstetric services shall ensure the backup supervision of his or her services by a physician with equivalent credentials.
- 2) Neonatal activities shall be directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics sub-board of neonatal/perinatal medicine, or a licensed osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Pediatricians/Neonatal-Perinatal Medicine. The director of the neonatal services shall ensure the backup supervision of his or her services by a physician with equivalent credentials.
- 3) An administrator/manager with a master's degree shall direct, in collaboration with the medical directors, the planning, development and operation of the non-medical aspects of the Level III hospital and its programs and services.
  - A) The obstetric and newborn nursing services shall be directed by a full-time nurse experienced in perinatal nursing, with a master's degree.
  - B) Half of all neonatal intensive care direct nursing care hours shall be provided by registered nurses who have two years or more of nursing experience in a Level III NICU. All NICU direct nursing care hours shall be provided or supervised by registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the NICU. All nursing staff working in the NICU shall have yearly competence assessment in neonatal intensive care nursing.

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- 4) Obstetric anesthesia services under the direct supervision of a board-certified anesthesiologist with training in maternal, fetal and neonatal anesthesia shall be available 24 hours a day. The directors of obstetric anesthesia services shall ensure the backup supervision of their services when they are unavailable.
- 5) Pediatric-neonatal respiratory care services shall be directed by a full-time respiratory care practitioner with a bachelor's degree.
  - A) The respiratory care practitioner responsible for the NICU shall have at least three years of experience in all aspects of pediatric and neonatal respiratory care at a Level III NICU and completion of the neonatal/pediatrics specialty examination of the National Board for Respiratory Care.
  - B) Respiratory care practitioners with experience in neonatal ventilatory care shall staff the NICU according to the respiratory care requirements of the patient population, with a minimum of one dedicated neonatal respiratory care practitioner for newborns on assisted ventilation, and with additional staff provided as necessary to perform other neonatal respiratory care procedures.
- 6) A physician for the program shall assume primary responsibility for initiating, supervising and reviewing the plan for management of distressed infants in the delivery room. Hospital policies and procedures shall assign responsibility for identification and resuscitation of distressed neonates to individuals who are both specifically trained and immediately available in the hospital at all times. Capability to provide neonatal resuscitation in the delivery room may be satisfied by current completion of a neonatal resuscitation program by medical, nursing and respiratory care staff or a rapid response team.
- 7) A board-certified or active candidate obstetrician shall be present and available in the hospital 24 hours a day. Maternal-fetal medicine consultation shall be available 24 hours a day.
- 8) Medical director-neonatal: to direct the neonatal portion of the program. Neonatal activities shall be directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics Sub-Board of

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Neonatal/Perinatal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Pediatricians/Neonatal-Perinatal Medicine. The directors of the neonatal services shall ensure the back-up supervision of their services when they are unavailable.

- 9) Neonatal surgical services shall be supervised by a board-certified surgeon or active candidate in pediatric surgery appropriate for the procedures performed at the Level III hospital.
- 10) Neonatal surgical anesthesia services under the direct supervision of a board-certified anesthesiologist with extensive training or experience in pediatric anesthesiology shall be available 24 hours a day.
- 11) Neonatal neurology services under the direct supervision of a board-certified or active candidate pediatric neurologist shall be available for consultation in the NICU 24 hours a day.
- 12) Neonatal radiology services under the direct supervision of a radiologist with extensive training or experience in neonatal radiographic and ultrasound interpretation shall be available 24 hours a day.
- 13) Neonatal cardiology services under the direct supervision of a pediatric board-certified or active candidate by the American Board of Pediatrics sub-board of pediatric cardiology shall be available for consultation 24 hours a day. In addition, cardiac ultrasound services and pediatric cardiac catheterization services by staff with specific training and experience shall be available 24 hours a day.
- 14) A board-certified or active candidate ophthalmologist with experience in the diagnosis and treatment of the visual problems of high-risk newborns (e.g., retinopathy of prematurity) shall be available for appropriate examinations, treatment and follow-up care of high-risk newborns.
- 15) Pediatric sub-specialists with specific training and extensive experience or subspecialty board certification or active candidacy (where applicable) shall be available 24 hours a day, including, but not limited to, pediatric urology, pediatric otolaryngology, neurosurgery, pediatric cardiothoracic surgery

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and pediatric orthopedics appropriate for the procedures performed at the Level III hospital.

- 16) Genetic counseling services shall be available for inpatients and outpatients, and the hospital shall provide for genetic laboratory testing, including, but not limited to, chromosomal analysis and banding, fluorescence in situ hybridization (FISH), and selected allele detection.
- 17) The Level III hospital shall designate at least one person to coordinate the community nursing follow-up referral process, to direct discharge planning, to make home care arrangements, to track discharged patients, and to ensure appropriate enrollment in a developmental follow-up program. The community nursing referral process shall consist of notifying the follow-up nurse in whose jurisdiction the patient resides of discharge information on all patients. The Illinois Department of Human Services will identify and update referral resources for the area served by the unit. The hospital shall establish a protocol that defines the educational criteria necessary for commonly required home care modalities, including, but not limited to, continuous oxygen therapy, electronic cardio-respiratory monitoring, technologically assisted feeding and intravenous therapy.
- 18) One or more full-time social workers with perinatal/neonatal experience shall be available to the Level III hospital.
- 19) One registered pharmacist with experience in perinatal pharmacology shall be available for consultation on therapeutic pharmacology issues 24 hours a day.
- 20) One dietitian with experience in perinatal nutrition shall be available to plan diets and education to meet the special needs of high-risk mothers and neonates in both inpatient and outpatient settings.
- ~~1) The Level III facility shall be responsible for provision of continuing education for medical, nursing, respiratory therapy, and other staff providing general, intermediate, and intensive care perinatal services with evidence of a yearly competence assessment appropriate to the patient population served.~~
- ~~2) The Level III facility shall accept all medically eligible Illinois residents.~~

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~~Medical eligibility is to be determined by the obstetrical or neonatal director or his/her designee based on the Department's standards for "Criteria for High-Risk Identification (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists)." If the facility is unable to accept the patient referred, the unit shall arrange for admission to another Level III facility or appropriate Level II facility.~~

- 3) ~~The Level III facility shall provide or arrange emergency transportation of patients referred to the unit in accordance with guidelines for interhospital care of the perinatal patient (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists). Decisions relating to transportation shall be made by the appropriate neonatal or obstetric medical director or his/her designee. The director shall determine:~~
  - A) ~~When to dispatch transportation from the facility or to use transportation facilities from the referring hospital;~~
  - B) ~~When to use ground or air transportation;~~
  - C) ~~The kind of vehicle to be used;~~
  - D) ~~The staff who should accompany the patient (nurse, house staff, attending physician, respiratory therapist, or other related personnel) assuring that the staff selected is trained and prepared in emergency obstetrics or neonatology. The facility shall provide any staff attendants required to transport the patient when the trip is dispatched from the facility.;~~
  - E) ~~Whether transportation can be delayed;~~
  - F) ~~Priorities of need;~~
  - G) ~~Recommendations for support care to stabilize the patient until transport.~~
- 4) ~~Medical director-neonatal: to direct the neonatal portion of the program. Neonatal activities shall be directed and supervised by a full-time~~

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~~pediatrician certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Pediatricians/Neonatal-Perinatal Medicine. The directors of the neonatal services shall ensure the back-up supervision of their services when they are unavailable.~~

- 5) ~~Medical director-obstetrics: to direct the obstetric portion of the program. Level III obstetric activities shall be directed and supervised by a full-time subspecialty obstetrician certified by the American Board of Obstetrics and Gynecology in the subspecialty of Maternal and Fetal Medicine or a licensed osteopathic physician with equivalent training and experience and certified by the American Osteopathic Board of Obstetricians and Gynecologists. Obstetric anesthesia services under the direct supervision of a board-certified anesthesiologist with training in maternal, fetal and neonatal anesthesia shall be available 24 hours a day. The directors of the obstetric services shall ensure the back-up supervision of their services when they are unavailable.~~
- 6) ~~An administrator/manager with a master's degree: to direct, in collaboration with the medical directors, the planning, development and operations of the non-medical aspects of the Level III facility and its programs and services.~~
- 7) ~~Continuing education for health professionals.~~
- 8) ~~Reporting program information: the Level III facility shall provide data relating to its activities and report information as required by the Department. Admission data, mortality, morbidity and other required data shall be reported on all admissions to this unit. This will include full compliance with the Adverse Pregnancy Outcomes Reporting System and the Perinatal Tracking System.~~
- 9) ~~The Level III facility shall have a clearly identifiable telephone and facsimile number, either a special number or a specific extension answered by unit personnel for receiving consultation requests and requests for admissions. This number shall be kept current with the Department and with the regional perinatal network.~~

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- 10) ~~The medical co-directors of the Perinatal Center shall be responsible for developing a system ensuring adequate physician-to-physician communications. Communications with referring physicians of patients admitted shall be sufficient to report patient progress before and at time of discharge.~~
- 11) ~~Continuous electronic maternal-fetal monitoring and staff knowledgeable in its use and interpretation shall be available 24 hours a day. In addition, the Level III facility shall provide appropriate ultrasound available on the OB floor.~~
- 12) ~~The Level III facility shall designate at least one person to coordinate the community nursing follow-up referral process, to direct discharge planning, to make home care arrangements, to track discharged patients, to ensure appropriate enrollment in a developmental follow-up program, and to collect outcome information. The community nursing referral process shall consist of notifying the follow-up nurse, in whose jurisdiction the patient resides, of discharge information on all patients. The Department shall identify and update referral resources for the area served by the unit.~~
- 13) ~~The Level III facility shall establish policies and procedures for the referral or transport of high-risk mothers and infants who require specialized care or services not currently available at the Level III facility to the appropriate facility that can provide the service needed.~~
- 14) ~~The Level III facility shall establish policies and procedures for the return transfer of high-risk mothers and infants to the referring facility when they no longer require the specialized care and services of the Level III facility.~~
- 15) ~~The pediatric-neonatal respiratory therapy services shall be directed by a full-time licensed respiratory care practitioner with at least three years experience in all aspects of pediatric and neonatal respiratory therapy, preferably with a bachelor's degree and one successful completion of the neonatal/pediatrics specialty examination of the National Board for Respiratory Care.~~
- 16) ~~A physician for the program shall be designated to assume primary responsibility for initiating, supervising and reviewing the plan for management of depressed infants in the delivery room. Policies and~~

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~~procedures shall assign responsibility for identification and resuscitation of distressed neonates to individuals who are both specifically trained and available in the hospital at all times, such as another physician, a nurse with training and experience in neonatal resuscitation or licensed respiratory care practitioner. Individuals assigned to perform neonatal resuscitation shall have documented evidence of current completion of a neonatal resuscitation course. It is further recommended that physicians and/or advanced practice nurses who care for newborns have documented evidence of completion of a neonatal resuscitation course.~~

- 17) ~~To provide for mechanical ventilation of newborn infants beyond the immediate stabilization, a physician or advanced practice nurse experienced in the management of mechanically ventilated infants must be present in the hospital during the entire time that the infant receives mechanical ventilation. The Level III facility shall provide suitable backup systems and planning to prevent and respond appropriately to sudden power outage, oxygen system failure, and interruption of medical-grade compressed air delivery.~~
- 18) ~~To care for the high risk pregnancy and for resulting infants whose birth weight is less than 1250 grams or whose gestational age is less than 30 weeks, the Level III facility shall have the perinatal leadership detailed above as well as the following resources:~~
- A) ~~A board certified or active candidate obstetrician shall be present and available in house, 24 hours a day. Maternal fetal medicine consultation must be available 24 hours a day. Obstetric anesthesia services under the direct supervision of a board certified anesthesiologist with extensive training or experience in maternal, fetal and neonatal anesthesia shall be available 24 hours a day.~~
  - B) ~~Preventive services designated to prevent, detect, diagnose and treat conditions known to occur in the high risk newborn, such as: cerebral hemorrhage, visual defects (retinopathy of prematurity), and hearing loss, and to provide appropriate immunization of high-risk newborns.~~
  - C) ~~A board certified or active candidate ophthalmologist with experience in the diagnosis and treatment of the visual problems of~~

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~~high-risk newborns (retinopathy of prematurity) shall be available to the nursery for appropriate examinations, treatment and follow-up care of high risk newborns.~~

- ~~D) Neonatal surgical (general), neonatal surgical anesthesia, and neonatal radiologic services detailed in subsections (c)(19)(A), (B), (C), and (D) of this Section.~~
- ~~E) Half of all neonatal intensive care direct nursing care hours shall be provided by licensed registered nurses who have two years or more nursing experience in a Level III neonatal intensive care unit. All neonatal intensive care direct nursing care hours shall be provided or supervised by licensed registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the Neonatal Intensive Care Unit. Evidence of current completion of a neonatal resuscitation course and a yearly competence assessment in neonatal intensive care nursing shall be required of all nursing staff working in the NICU.~~
- ~~F) Licensed respiratory care practitioners with experience in neonatal ventilatory care shall staff the NICU according to the respiratory care requirements of the patient population with a minimum of one dedicated neonatal licensed respiratory care practitioner for newborns on mechanical ventilators with additional staff provided as necessary to perform other neonatal respiratory care procedures. All direct respiratory care hours shall be provided or supervised by licensed respiratory care practitioners with 2 years or more neonatal ventilatory care experience at a Level III Neonatal Intensive Care Unit. Evidence of completion of a neonatal resuscitation course and a yearly competence assessment in neonatal respiratory pathophysiology and respiratory care technology are required of all staff providing respiratory care in the NICU.~~
- ~~G) Provide or develop a referral agreement with a follow-up clinic to provide neuro-developmental outcome data on the neonatal population. Institutional policies and procedures will describe the at-risk population and the referral neonatal procedure to be~~

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- ~~followed. Infants will be scheduled for assessments at regular intervals. Neurodevelopmental assessments will be communicated to the primary care physicians. Referrals will be made for interventional care in order to minimize neurologic sequelae. A system shall be established to track, record, and report neurodevelopmental outcome data for the population, as required to support network CQI activities as developed by the Statewide Quality Council.~~
- H) ~~A protocol shall be established that defines the educational criteria necessary for commonly required home care modalities, including but not limited to continuous oxygen therapy, electronic cardiorespiratory monitoring, technologically assisted feeding and intravenous therapy.~~
  - I) ~~One registered pharmacist with experience in perinatal pharmacology shall be available for consultation on therapeutic pharmacology issues 7 days a week.~~
  - J) ~~One or more full-time licensed medical social workers with relevant experience shall be dedicated to the Level III perinatal facility. Time allotment should be based on the size of the unit and characteristics and needs of the patient population.~~
- 19) ~~In order to provide comprehensive neonatal surgical services, including but not limited to infants with congenital anomalies or congenital heart disease, the Level III facility shall provide the following resources:~~
- A) ~~Neonatal surgical services shall be available 24 hours a day and shall be supervised by a surgeon board certified or board eligible in pediatric surgery appropriate for the procedures performed at the Level III facility.~~
  - B) ~~Surgical specialists with specific training and extensive experience and/or subspecialty board certification or active candidacy (where applicable) shall be available 24 hours a day in the following subspecialties: pediatric urology, pediatric otolaryngology, neurosurgery, pediatric cardiothoracic surgery, pediatric orthopedies appropriate for the procedures performed at the Level~~

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~~III facility.~~

- ~~C) Neonatal surgical anesthesia services under the direct supervision of a board-certified anesthesiologist with extensive training or experience in pediatric anesthesiology shall be available 24 hours a day.~~
  - ~~D) Neonatal radiology services under the direct supervision of a radiologist with extensive training or experience in neonatal radiographic and ultrasound interpretation shall be available 24 hours a day.~~
  - ~~E) Neonatal neurology services under the direct supervision of a board-certified or active candidate pediatric neurologist shall be available for consultation in the intensive care nursery 24 hours a day.~~
  - ~~F) Neonatal cardiology services under the direct supervision of a pediatrician board certified or active candidate by the American Board of Pediatrics sub-board of pediatric cardiology shall be available to consult in the nursery 24 hours a day. In addition, cardiac ultrasound services and pediatric cardiac catheterization services by staff with specific training and experience shall be available as needed 24 hours a day.~~
  - ~~G) The neonatal intensive care nursing and respiratory care resource requirements listed in subsections (c)(15) and (18) of this Section, respectively.~~
  - ~~H) Genetic counseling services for inpatients and outpatients and appropriate provisions for genetic laboratory testing, including but not limited to chromosomal analysis and banding, FISH, and selected allele detection.~~
- 20) ~~The obstetric newborn nursing services shall be directed by a full-time nurse experienced in perinatal nursing preferably with a master's degree.~~
- 21) ~~One or more full-time licensed medical social workers with relevant experience shall be dedicated to the Level III perinatal facility. Time~~

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~~allotment will be based on the size of the unit and characteristics and needs of the patient population.~~

- 22) ~~Respiratory therapists with experience in neonatal care should be available with staffing based on the respiratory care requirements of the patient population (minimum of 1 respiratory therapist for every 4 patients on mechanical ventilators with additional staff provided as necessary to perform other respiratory care procedures).~~
- 23) ~~One registered dietitian with experience in perinatal nutrition and a certified diabetic educator shall be available to plan diets to meet the special needs of high-risk mothers and neonates in both inpatient and outpatient settings.~~

d) Application for Hospital Designation, Redesignation or Change in Network

- 1) To be designated or to retain designation, a hospital shall submit the required application documents to the Department. For information needed to complete any of the processes, see Section 640.50 and Section 640.60.
- 2) The following information shall be submitted to the Department to facilitate the review of the hospital's application for designation or redesignation:
- A) Appendix A (fully completed);
- B) Resource Checklist (fully completed) (Appendices L, M, N and O);
- C) A proposed letter of agreement between the hospital and the APC (unsigned); and
- D) The curriculum vitae for all directors of patient care, i.e., obstetrics, neonatal, ancillary medical, and nursing (both obstetrics and neonatal).
- 3) When the information described in subsection (d)(2) is submitted, the Department will review the material for compliance with this Part. This

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documentation will be the basis for a recommendation for approval or disapproval of the applicant hospital's application for designation.

- 4) The medical co-directors of the APC (or their designees), the medical directors of obstetrics and maternal and newborn care, and a representative of hospital administration from the applicant hospital shall be present during the PAC's review of the application for designation.
  - 5) The Department will make the final decision and inform the hospital of the official determination regarding designation. The Department's decision will be based upon the recommendation of the PAC and the hospital's compliance with this Part, and may be appealed in accordance with Section 640.45. The Department will consider the following criteria to determine if a hospital is in compliance with this Part:
    - A) Maternity and Neonatal Service Plan (Subpart O of the Hospital Licensing Requirements);
    - B) Proposed letter of agreement between the applicant hospital and its APC in accordance with Section 640.70;
    - C) Appropriate outcome information contained in Appendix A and the Resource Checklist;
    - D) Other documentation that substantiates a hospital's compliance with particular provisions or standards of perinatal care set forth in this Part; and
    - E) Recommendation of Department program staff.
- d) Exceptions to Level III—Standards of Care
- 1) Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes, and geography in the regional perinatal network. These exceptions are not intended to circumvent the Level III capabilities designation. The applicant facility or the Perinatal Center may seek the advice and consultation of the Department as well as the Perinatal Advisory Committee in regard to the conditions necessary for an exception.

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- 2) ~~Exceptions to the standards of care of this Part may be granted when the facility requesting an exception demonstrates that the resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level III facility or Perinatal Center in its Regional Perinatal Network. The proposed exceptions shall be determined by the applicant facility and its Perinatal Center based primarily on outcomes.~~
- 3) ~~If the applicant facility and its Perinatal Center cannot reach agreement on any aspect of the exceptions to the standards of care of this Part, the applicant facility or Perinatal Center shall seek the advice and consultation of the Perinatal Advisory Committee (i.e., subcommittee on facility designation). Any exception to the standards of care of this Part shall be clearly defined in the proposed letter of agreement and approved by the Department before implementing the exceptions or patient care services being requested. The Department shall permit a period of testing or trial (probation) to demonstrate that the applicant facility's resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for any Level III facility.~~
- 4) ~~If a dispute between the applicant facility and its Perinatal Center cannot be resolved after consultation with the Perinatal Advisory Committee (i.e., subcommittee on facility designation), then the applicant facility, the Perinatal Center or the Perinatal Advisory Committee shall submit the dispute to the Department for settlement. The Department shall review all of the relevant information and documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care and the recommendations of the Perinatal Advisory Committee in deciding or settling a dispute. The Department shall inform the applicant facility, the Perinatal Center and the Perinatal Advisory Committee of its decision or judgment.~~
- 5) ~~The following information shall be submitted to the Perinatal Advisory Committee (i.e., subcommittee on facility designation) to facilitate the review of the applicant facility's application for designation with exceptions to the standards of care of this Part:~~
  - A) ~~A proposed letter of agreement (unsigned).~~

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- B) ~~The curriculum vitae for all directors of patient care, i.e., OB, neonatal, nursing (OB and neonatal).~~
- C) ~~Appendices A and B (fully completed).~~
- D) ~~A letter from the Perinatal Center that includes the following information:~~
  - i) ~~List of the exceptions being requested.~~
  - ii) ~~Sufficient data/information to demonstrate that the quality of care (outcomes) of the applicant facility are substantially equivalent to the appropriate standards as outlined in this Section.~~
  - iii) ~~A description of the monitoring system used when a consultation occurs between the attending physician at the referring hospital and the physician consultant at the Perinatal Center or Level III facility and it is determined that the mother or newborn infant should stay in the community hospital for care.~~
  - iv) ~~A description of any arrangements made between the applicant facility and the Perinatal Center to seek or insure quality improvement.~~
- 6) ~~When the information described is submitted to the Perinatal Advisory Committee, it shall review the material for compliance with the Regionalized Perinatal Health Care Code, and shall make a recommendation for approval or disapproval of the applicant facility's application for designation with exceptions to the Department.~~
- 7) ~~The medical co-directors of the Perinatal Center (or their designees) and the medical directors of OB and neonatology and a representative of hospital administration from the applicant facility shall be present during the Perinatal Advisory Committee's review of the applicant facility's application for designation with exceptions.~~
- 8) ~~The Department shall review the submitted materials and any other~~

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~~documentation that clearly substantiates the facility's compliance with particular provisions or standards of perinatal care, including quality of care (outcomes) information and the recommendation of the Perinatal Advisory Committee, and shall make a recommendation to the Director of Public Health concerning the approval or disapproval of the applicant facility's application for designation with exceptions.~~

- 9) ~~The Director of Public Health shall make the final decision and inform the facility of the official determination regarding designation with exceptions to the standards of care of this Part. The Director's decision shall be based upon the recommendation of the Perinatal Advisory Committee and the facility's compliance with the Regionalized Perinatal Health Care Code, and may be appealed in accordance with Section 640.45. The Director of Public Health shall consider the following criteria or standards to determine if a facility is in compliance with the Code:~~
- ~~A) Maternity and Neonatal Service Plan (Subpart O of the Illinois Hospital Licensing Requirements).~~
  - ~~B) Proposed letter of agreement between the applicant facility and its Perinatal Center in accordance with the provisions described in Section 640.70.~~
  - ~~C) Appropriate outcome information contained in Appendices A and B.~~
  - ~~D) Other documentation that clearly substantiates a facility's compliance with particular provisions or standards of perinatal care.~~
  - ~~E) Recommendation of Department program staff.~~
- e) ~~The Department, in conjunction with the Perinatal Advisory Committee, shall develop a plan for the evaluation of the Regionalized Perinatal Health Care Code to include, but not be limited to, morbidity and birthweight specific mortality indicators. A report shall be prepared annually.~~
- f) ~~The Department shall develop a plan wherein the degree of compliance with these standards is determined on a periodic basis not to exceed three years.~~

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- g) ~~The standards identified throughout this Section do not apply to infants who, after having completed initial therapy, are transferred back to the referring hospital for continuing care. The capability of the hospital to provide necessary services for such infants is to be determined by mutual consent with the Perinatal Center and the issue addressed in the letter of agreement.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.44 Administrative Perinatal Center**

~~a) To be designated as an APCa Perinatal Center, a hospital facility shall submit an application apply to the Department for a grant to provide financial support to assist the Department in the implementation and oversight of the Regionalized Perinatal Health Care Program; the designation, and shall comply with all of the conditions described for intensive (Level III) perinatal care in Section 640.43; and shall comply with all of the conditions described in Subpart O of the Hospital Licensing Requirements. The APC (77 Ill. Adm. Code 250) promulgated by the Department which are applicable to the level of care necessary for the patients served, and in addition shall comply with the following:~~

a) Administrative Perinatal Center – General Provisions

- 1) ~~An APCA Perinatal Center shall be a university or university-affiliated hospital, having Level III hospital designation. An APC may be composed of one or more institutions. The APC shall be facility responsible for the administration and implementation of the Department's regionalized perinatal health care program, including but not limited to:~~

- ~~A) Continuing continuing education for health care professionals;—A Perinatal Center may be composed of one or more institutions.~~
- ~~B) Leadership and implementation of CQI projects, including morbidity and mortality reviews at regional network hospitals;~~
- ~~C) Maternal and neonatal transport services;~~
- ~~D) Consultation services for high-risk perinatal patients;~~
- ~~E) Follow-up developmental assessment programs; and~~

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- F) Laboratory facilities and services available to regional network hospitals.
- 2) An APC shall~~A Perinatal Center must~~ be capable of providing the highest level of care within a regional network appropriate to maternal and neonatal high-risk patients. The following services shall be available:
- A) Consultants in the various medical-pediatric-surgical subspecialties including, but not limited to, cardiac, neurosurgery, genetics, and other support services;
  - B) Follow-up developmental assessment program;
  - C) Maternal and neonatal transport services; and
  - D) Laboratory facilities available to the hospitals within the regional perinatal network.
- b) The Department will designate an APC within~~Within~~ each regional perinatal network ~~there shall be a Perinatal Center designated by the Department~~ to be responsible for the administration and implementation of the Department's Regionalized Perinatal Health Care Program.
- c) The APC~~Perinatal Center~~ will be responsible for providing leadership in the design and implementation of the Department's Continuous Quality Improvement (CQI Program, including)~~program. This will include~~ the establishment and regularly scheduled meetings~~maintenance~~ of a regional quality improvement structure (Regional Quality Council), ~~for the implementation of the Department's Quality Improvement in Perinatal Program, (QIPP).~~
- d) The APC shall establish a Joint Mortality and Morbidity Review Committee with the affiliated regional network hospitals. The Committee shall review all perinatal deaths and selected morbidity, including, but not limited to, transports of neonates born with handicapping conditions, or developmental disabilities, or unique medical conditions. This review shall also include a periodic comparison of total perinatal mortality and the numbers attributable to categories of complications. Membership on the Committee shall include, but not be limited to, pediatricians, obstetricians, family practice physicians, nurses, quality assurance, pathology, and

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hospital administration staff and representatives from the hospital's APC. The network administrator shall prepare a yearly synopsis of the Regional Perinatal Network's perinatal deaths. This synopsis shall include statistical information, as well as an identification of the factors contributing to deaths that are identified as potentially avoidable. The synopsis shall be shared with the Regional Quality Council. The Council shall develop, for the Network, an action plan to address issues of preventability. The Council's action plan shall be forwarded to the Department. The membership of the Council shall include representatives from all levels and disciplines of perinatal health care providers.

e) Perinatal Program Oversight Agency Review

- 1) The Department shall work in conjunction with the APCs to conduct site visits at network hospitals to assure~~develop a plan that has the degree of~~ compliance with this Part~~Section's standards determined~~ on a periodic basis not to exceed three years.
- 2) The requirements of standards identified throughout this Part~~Section~~ do not apply to infants who, after having completed initial therapy, are transferred back to the referring hospital for continuing care. The capability of the hospital to provide necessary services for these infants shall~~is to~~ be determined by mutual consent with the APC~~Perinatal Center~~ and ~~the issue~~ addressed in the letter of agreement.
- 3) APCs shall provide information to the Department no less frequently than quarterly. These reports shall include, but not be limited to, network education activities; network meetings; overview of CQI activities; schedule of mortality and morbidity review meetings; and schedule of proposed and completed network hospital site visits. The Department shall develop a methodology for incorporating perinatal outcomes information into the perinatal facility designation, redesignation, and exception processes. The Department shall seek input on the development of this methodology from the Perinatal Advisory Committee. This input shall include, but not necessarily be limited to, the identification and selection of indicators, defining standards for each level of care and the methodology for applying the standards to the designation, redesignation and/or exception processes.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.45 Department of Public Health Agency Action**a) Department Review

- 1) The Department will develop a plan for determining the degree of compliance with this Part on a periodic basis not to exceed three years.
- 2) During the site visit, the hospital will receive a determination of substantial compliance or substantial failure.

b) Department Oversight

The Department may deny designation or redesignation or revoke designation of any hospital that Any designated facility which fails to achieve substantial compliance ~~comply~~ with the requirements for its designation may have its application for designation or redesignation set forth in this Part denied or its designation revoked by the Department. The Department ~~will~~ shall consider the following factors ~~relevant~~ in deciding whether to deny designation or redesignation or to revoke designation: failure to comply with the requirements for designation will result in denial or revocation:

- 1) Failure to complete the letter of agreement within 90 days after receipt of the official site visit report;-
- 2) Failure to have and to comply with an approved Maternity Maternal and Neonatal Service Plan;-
- 3) Failure to complete the site visit and accompanying site visit report documentation, i.e., Standardized Perinatal Site Visit Protocol and Outcome Oriented Data;-
- 4) Failure to comply Applicant facility has not demonstrated compliance with all of the requirements of this Part for the level of designation.
- 5) Failure to participate Applicant facility has failed to demonstrate adequate participation in and comply with ontinuous Quality Improvement (CQI programs) activities, including the Regional Quality Council or other programs designed or implemented by the APC ~~implemented by the Perinatal Center~~ or the Department;-

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- 6) Failure to notify the Department of the loss of, or change in, an essential resource required for its level of designation;
- b) ~~The circumstances under which an application or designation may be denied or revoked include:~~
- 1) ~~failure to comply with the requirements for designation has been noted by the Department; and~~
  - 2) ~~when the institution has been notified by the Department as to the specific item or items not in compliance with the requirements for designation, and when the institution has not corrected the matter within a reasonable period of time (90 days).~~
- c) The Department will notify the hospital within 30 days after the site visit as to whether the hospital has achieved substantial compliance with this Part. The notification will include specific requirements with which substantial compliance has not been achieved. If the hospital has not achieved substantial compliance within 90 days after having received the notice, the Department will deny or revoke the designation. If progress toward substantial compliance is being made, per written documentation of the APC, the Department will continue to work with the hospital and its APC to achieve designation.
- d)e) The ~~provisions of the~~ Illinois Administrative Procedure Act ~~[5 ILCS 100]~~ and the Department's ~~Rules of Practice and Procedure~~ infor Administrative Hearings ~~(77 Ill. Adm. Code 100)~~ shall apply to all hearings challenging Department decisions, including those related to designation, redesignation, and denial or revocation of designation.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.50 Designation and Redesignation of Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities, ~~and~~ Level III Perinatal Hospitals and Administrative Perinatal Centers~~Facilities~~**

- a) The ~~hospital~~facility shall declare by means of a letter of intent to the Department and the affiliated APC that it seeks designation as a hospital with no OB services, or as a ~~facility for the delivery of general perinatal care (Level I), or intermediate~~

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~~perinatal care (Level II, or Level II with Extended Neonatal Capabilities), or intensive care (Level III) in a one of the Regional Perinatal Network Networks of the Illinois Perinatal Health Care Program.~~

- b) The Department ~~will~~shall acknowledge the letter of intent.
- c) The ~~APC Perinatal Center~~ shall arrange a site visit to the applicant ~~hospital facility~~. The hospital shall prepare the designation/redesignation documents in accordance with Section 640.60. The site visit team for Level I, II, II with Extended Neonatal Capabilities, and III perinatal ~~hospitals facilities~~ shall consist of ~~five~~5 members: three from the ~~APC Perinatal Center~~ of the ~~hospital's Regional Perinatal Network hospital network~~, including the Directors of Neonatology and Maternal-Fetal Medicine or their designees and ~~the Perinatal Network Administrator~~; a representative of nursing; one representative from the PAC; and one representative of the Department. The site visit team shall review the capabilities of the applicant ~~hospital facility~~ based on the requirements outlined in the letter of agreement between the applicant ~~hospital facility~~ and the ~~APC Perinatal Center~~. The site visit team shall complete the Standardized Perinatal Site Visit Protocol (see Appendix A) ~~and Outcome Oriented Data (see Appendix B)~~ and submit these materials to the medical directors of the ~~hospital facility~~ visited for their review and comment within 30 days ~~after from~~ the date of the site visit. The APC shall collaborate with the Department to develop a summary site visit report within 60 days after the site visit. This report shall be sent to the hospital within 90 days after the site visit.
- d) The Department ~~will~~shall coordinate the site visit for ~~APCs Perinatal Centers~~. The team shall consist of ~~five~~5 members: one Director of Neonatology, ~~one Director of~~ Maternal-Fetal Medicine and ~~one Perinatal Network Administrator~~ Nursing from a non-contiguous Center; one representative from the PAC; and one representative of the Department. The Department shall collaborate with the site visit team to develop a summary site visit report within 60 days after the site visit. This report shall be forwarded to the hospital within 90 days after the site visit. The site visit team shall complete the Standardized Perinatal Site Visit Protocol and Outcome Oriented Data and submit these materials to the Perinatal Center for their review and comment within 30 days from the date of the site visit.
- e) ~~The complicated site visit report shall then be forwarded to the Department within 60 days from the date of the site visit. Department staff shall be available for technical and administrative consultation concerning the site visit.~~

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- f) ~~The Department, having received the information requested concerning the applicant facility, the site visit report and the letter of agreement between the applicant facility and the Perinatal Center, shall submit these materials to the Perinatal Advisory Committee for review. The applicant facility may request to appear or may be asked to appear before the Perinatal Advisory Committee during its review of the application.~~
- g) ~~When the information described in Section 640.60 is submitted to the Perinatal Advisory Committee, it shall review the material, and the report of the site visit, for compliance with the Regionalized Perinatal Health Care Code; and shall make a recommendation for approval or disapproval of the facility's application for designation to the Department.~~
- e)h) The Department will~~shall~~ review the submitted materials, any other documentation that clearly substantiates a hospital's facility's compliance with particular provisions or standards for perinatal care, and the recommendation of the PAC, Perinatal Advisory Committee, and ~~shall make a recommendation to the Director of Public Health concerning designation of the facility as an affiliated perinatal facility (Level I, Level II, Level II with Extended Capabilities, Level III) to a designated Perinatal Center in the Statewide Regionalized Perinatal Health Care Program.~~
- f)i) The Department will~~Director of Public Health shall~~ make the final decision and inform the hospital facility of the official determination regarding designation. The Department's Director's decision will~~shall~~ be based upon the recommendation of the PAC Perinatal Advisory Committee and the hospital's facility's compliance with this Part, the Regionalized Perinatal Health Care Code, and may be appealed in accordance with Section 640.45. A 12-month to 18-month follow-up review will be scheduled for any increase in hospital designation to assess compliance with the requirements of this Part that are applicable to the new level of designation. The Department Director of Public Health shall consider the following criteria ~~or standards~~ to determine if a hospital facility is in compliance with this Part, the Code:
- 1) Maternity and Neonatal Service Plan (Subpart O of the Hospital Licensing Requirements);

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- 2) Proposed letter of agreement between the applicant hospital and its APC in accordance with Section 640.70;
  - 3) Appropriate outcome information contained in Appendix A and the Resource Checklist (Appendices L, M, N and O);
  - 4) Other documentation that substantiates a hospital's compliance with particular provisions or standards of perinatal care set forth in this Part; and
  - 5) Recommendation of Department program staff.
- 1) ~~Confirmation of an approved Maternity and Neonatal Service Plan at the level of care for which the facility is seeking designation.~~
  - 2) ~~An approved letter of agreement between the applicant facility and its Perinatal Center in accordance with the provisions described in Section 640.70.~~
  - 3) ~~A completed Standardized Site Visit Protocol and Outcome Orientated Data report in accordance with the provisions described in Section 640.50(e)-(e).~~
  - 4) ~~Other documentation that clearly substantiates a facility's compliance with particular provisions or standards for perinatal care.~~
  - 5) ~~Recommendation of Department program staff.~~
- g)j) The Department will review all~~All~~ designations at least~~shall be reviewed by the Department~~ every three years or when the Department may deem necessary to assure that the designated hospitals~~facilities~~ continue to comply with the requirements of the perinatal plan. Circumstances that~~which~~ may influence the Department to review a hospital's~~facility's~~ designation more frequently~~other~~ than every three years could include:
- 1) A hospital's desire~~When a hospital wanted~~ to expand or reduce services;:-
  - 2) Poor perinatal outcomes;:-

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- 3) Change in APC Perinatal Center or Network affiliation;
- 4) Change in Availability of human resources that would have an impact on the hospital's ability to comply with the required resources for the level of designation; or to complete Department site visit.
- 5) An APC When a Perinatal Center finds and the Department concurs or determines that a hospital is not appropriately participating in and complying with Continuous Quality Improvement (CQI) programs activities and/or the Quality Improvement in Perinatal Program (QIPP).

hk) Existing designations shall be effective until redesignation is accomplished.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.60 Application Information for Hospital Facility Designation and Redesignation as a Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities, and Level III Perinatal Hospital Facilities and Administrative Perinatal Center, and Assurances Required of Applicants**

- a) Applicant hospitals facilities shall provide the Department with the following information based on standards and resources for the applicable level of designation. The information shall include, but not be limited to the following (see Appendix A): which may be included in its Maternity and Neonatal Service Plan or letter of agreement:
  - 1) A definition of the geographic area the hospital facility currently serves or plans to serve.
  - 2) A physical description of the hospital physical facility, compliance with Subpart O of the Hospital Licensing Requirements 77 Ill. Adm. Code 250, and a description of the maternity and nursery units currently in place or in preparation for operation should the hospital facility be designated.
  - 3) A physical description of the hospital's facility's staffing in accordance with this Part those additional standards or designation described in the Regionalized Perinatal Health Care Code as follows:

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- A) Social work and nutrition services shall be available through a hospital department for Level II and Level III designation.
- B) Names, titles and contact numbers shall be provided for the Director or Chairman of Maternal-Fetal Medicine, Neonatology, Obstetrics, Pediatrics and Neonatal Services, Chief Nursing Supervisor, Nursing Supervisor of Maternity Unit; names and contact ~~numbers~~~~number~~ of medical staff members in maternal-fetal medicine, obstetrics and gynecology, neonatology, ~~obstetric~~~~OB~~ anesthesiology, family practice, anesthesiology; listing of anesthesiologists, staff for respiratory therapy, nurse-midwives, and involved house staff.
- C) A description of the current nurse/patient ratios in the nursery, delivery room, postpartum floor and intermediate or intensive care newborn nurseries for all shifts.
- D) A description of the qualifications of nursing personnel involved in the newborn nursery, delivery room and postpartum area.
- E) A description of the staff plans to assure that maternity/nursery staff are trained and prepared to stabilize infants prior to transfer, and are available 24 hours a day.
- 4) A description giving evidence that the ~~hospital's~~~~facility's~~ laboratory, X-ray and respiratory therapy equipment and capabilities meet all ~~of the~~ conditions described in ~~77 Ill. Adm. Code 250~~, Subpart O ~~of the Hospital Licensing Requirements~~ and are available 24 hours a day in-house.
- A) ~~Continuous~~~~Evidence is required that continuous~~ electronic maternal-fetal monitoring ~~shall be~~~~is~~ available, and staff ~~with~~ knowledge in its use and interpretation ~~shall be~~~~is~~ available 24 hours a day for Level I, Level II, Level II with Extended ~~Neonatal~~ Capabilities, and Level III designation applicants.
- B) Level III and ~~APCs~~~~Perinatal Center~~ shall provide Level II ultrasound available on the ~~obstetric~~~~OB~~ floor.
- C) Level I ultrasound and staff knowledgeable in its use and

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interpretation shall be available at Level II ~~hospitals~~facilities on a 24-hour-a-day basis.

- 5) A description of the capabilities for or capabilities planned for (giving the start-up time); emergency neonatology surgery, listing specialists such as surgeons, trained or support staff for neonates, and a description of the capabilities for caesarean section and start-up time.
- 6) A description of the present plan for identification of high-risk maternity and neonatal patients and agreements for consultation with the APC Perinatal Center in cases of maternity and neonatal complications and neonates with handicapping conditions. This description shall include plans and agreements for providing:
  - A) Management of acute surgical or cardiac difficulties;
  - B) Genetic counseling ~~if should~~ a genetically related condition ~~is be~~ diagnosed in the neonate, or ~~if should~~ a parent or a known carrier ~~requests therequest such~~ services;
  - C) Information, counseling and referral to another health care provider for parents of neonates with handicapping conditions or developmental disabilities to ensure informed consent for treatment;
  - D) Counseling and referral services to another health care provider to assist these patients in obtaining habilitation and rehabilitation services;
  - E) A description of the types of patients the hospital facility will care for and the types of patients it will refer to the APC Perinatal Center.
- 7) A description of the history and current level of involvement with CQI Continuous Quality Improvement activities as designed and implemented by the APC Perinatal Center.
- 8) All of the information required for hospital facility designation or redesignation to the APC Perinatal Center with which it is seeking

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affiliation.

- b) The following [proceduresguidelines](#) shall govern the review of perinatal [hospitals facilities](#) applying for designation or redesignation:
- 1) Hospitals applying for perinatal designation or redesignation shall provide all [of](#) the information contained in [the](#) Standardized Perinatal Site Visit Protocol (Appendix A) [and the Resource Checklist \(see Appendices L, M, N and O\).](#)~~and Outcome Oriented Data (Appendix B).~~
  - 2) ~~The completed written documentation~~ [The completed Standardized Perinatal Site Visit Protocol and Outcome Oriented Data](#) shall be submitted to the Department [three weeks in advance of the scheduled site visit, along with the site visit report, and the letter of agreement.](#)
  - 3) The [Department will send the completed site visit documentation Standardized Perinatal Site Visit Protocol and Outcome Oriented Data shall be sent by the Department to the PAC members,](#) no less than [two weeks](#)~~one week~~ in advance of the [PAC](#) meeting, to facilitate [PAC](#)~~their~~ review of the applicant [hospital](#)~~facility~~.
  - 4) A representative of the [APC Perinatal Center and representatives of the hospital for which the application is being considered](#) shall be present at the PAC meeting to respond to questions or concerns of PAC members regarding the [hospital's facility's](#) application for designation or redesignation. The representative may also be asked to present an oral summary of the applicant [hospital's facility](#) and the [APC's Perinatal Center's](#) reasons for recommending/not recommending designation or redesignation to the PAC. [A 12- to 18- month follow-up will be scheduled for any increase in designation to assess compliance with the new level of designation.](#)
  - 5) The Department [will request that](#)~~shall ask~~ the [APC Perinatal Center to](#) conduct a follow-up site visit to the [hospital facility for review for designation or redesignation](#) if the initial site visit is more than [six](#)~~6~~ months prior to submission [to the PAC for review by PAC for designation or redesignation.](#) [Approval](#)~~In such cases, approval~~ shall be contingent upon receiving the findings of the follow-up site visit.

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- c) The following procedure shall be followed to change network affiliation for an individual hospital:
- 1) The hospital requesting a change in affiliation shall submit a written request to the Department. The existing APC shall provide information for the site visit and review, as requested. The receiving APC shall conduct the site visit in preparation for a change in network.
  - 2) Representatives from the hospital and receiving APC shall appear before the PAC and shall present appropriate documentation as described in Appendix A.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.70 Minimum Components for Letters of Agreement ~~Agreements~~ Between Non-Birthing Center, Level I, Level II, Level II with Extended Neonatal Capabilities, or Level III Perinatal Hospitals ~~Facilities~~ and Their Administrative Perinatal Center**

The following components, at a minimum, shall be addressed in a letter of agreement between the applicant hospital ~~facility~~ and its APC ~~Perinatal Center~~:

- a) A description of how maternal and neonatal patients with potential complications ~~problems~~, including handicapping conditions or developmental disabilities, will be identified.
- b) A description of the types of maternal and neonatal cases in which consultation from the APC ~~Perinatal Center~~ or Level III hospital ~~facility~~ shall ~~will~~ be sought and from which patients shall ~~will~~ be selected for transfer. This description shall address those high-risk mothers or neonates with: ~~1) Handicapping conditions, developmental disabilities, or medical conditions that are life threatening and require transport to a Perinatal Center or a Level III facility. 2) handicapping~~ Handicapping conditions, developmental disabilities, or medical conditions that may require additional medical and surgical treatment and support services, but would not, however, require transport to an APC ~~a Perinatal Center~~ or Level III hospital ~~facility~~.
- c) A description of how the APC ~~Perinatal Center~~ or Level III hospital ~~facility~~ will report a patient's ~~patients'~~ progress to the referring physicians, and the criteria for return of the patient ~~patients~~ from the APC ~~Perinatal Center~~ or Level III

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hospital facility to an affiliated hospital facility closer to the patient's/patients' home.

- d) A description of the methods for transporting high-risk mothers and neonates with physiological support in transit.
- e) A description of the information, counseling and referral services available within the local community and the regional network for parents or potential parents of neonates with handicapping conditions or developmental disabilities.
- f) A description of the professional educational outreach program for the regional network, including how efforts will be coordinated.
- g) ~~A provision requiring the establishment of a Joint Mortality and Morbidity Review Committee to review all perinatal deaths and selected morbidity. The review shall include the births of children born with handicapping conditions or developmental disabilities, utilizing criteria of case selection developed by the PAC to determine the appropriateness of diagnosis and treatment of neonates born with a handicapping condition or developmental disability and the adequacy of procedures to prevent such disabilities or the loss of life (Section 3(g) of the Act). This review shall also include a periodic comparison of total perinatal mortality and the relative numbers attributable to various categories of complications. Membership on the Committee should include pediatricians, obstetricians and representation from their designated Perinatal Center. Membership on the Committee may also include general family practitioners, with specified support staff of the hospital. A yearly synopsis of the Perinatal Network's perinatal deaths will be prepared by the Network Administrator. This synopsis will include statistical information, as well as an identification of the factors contributing to deaths assigned a disposition of potentially avoidable. The synopsis will be shared with the Regional Quality Council. An action plan to address issues of preventability will be developed, for the Network, by the Regional Quality Council. The Regional Quality Council's action plan will be forwarded to the State-Wide Quality Council. The membership of the Regional Quality Council shall include representatives from all levels and disciplines of perinatal healthcare providers.~~
- gh) A description of the regional perinatal network's program for medical and home nursing follow-up, describing systems of liaisons, with a letter of agreement from the agency providing the home nursing follow-up services.

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- hi) A description of the methodologies used to monitor, evaluate, and improve the quality of health care services provided ~~by~~under the auspices of the applicant ~~hospital facility~~, including ~~a clear set of~~ expectations of both the ~~APC Perinatal Center~~ and applicant ~~hospital facility~~ on joint participation in ~~CQI~~continuous quality improvement activities.
- ij) A ~~requirement that the hospital shall provide~~stipulation requiring the provision of information, counseling and referral services to another health care provider to parents or potential parents of neonates with handicapping conditions or developmental disabilities upon the identification of the handicapping conditions and developmental disabilities, to assist in obtaining habilitation, rehabilitation, and special education services.
- jk) A ~~requirement for provision requiring~~ evaluation and consultation with the ~~APC Perinatal Center~~ or Level III ~~hospital facility~~ and referral to the ~~APC Perinatal Center~~ or Level III ~~hospital facility~~, when determined appropriate by the perinatal conditions or developmental disabilities, within 24 hours after the identification of the conditions (specific conditions ~~shall~~must be defined in the letter of agreement).
- kl) A ~~requirement that provision requiring the establishment of~~ procedures for referral to appropriate state and local education service agencies of children having an identified handicapping condition or developmental disability requiring evaluation and assessment under such agencies shall be established. The procedures shall include ~~a provision for~~ obtaining parental consent prior to release of information to the appropriate state and local educational service agencies.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.80 Regional Perinatal Networks – Composition and Funding**

- a) Regional Perinatal Networks, as defined in Section 640.20, may include any number and combination of ~~hospitals providing~~hospital-based maternity and newborn ~~services~~facilities functioning at one of the ~~three~~ levels of perinatal care, according to policies and practices described in their letters of agreement. Where more than one Level III ~~hospital facility~~ provides services within a Regional Perinatal Network~~regional perinatal network~~, a letter of agreement with the ~~APC Perinatal Center~~ shall describe how each will participate in the provision of

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services included in Section 640.40(e) of this Part. [Regional Perinatal Networks](#) Such regional perinatal networks may also include other agencies, institutions and individuals providing a complete range of perinatal health services, including preconceptional, prenatal, perinatal and family follow-up care services, as part of the regional network.

b) The Department ~~will~~ may allocate funds for perinatal health services provided through Regional Perinatal Networks.

1) ~~Sections 630.30 through 630.70 of the Department's "Maternal and Child Health Services Code" (77 Ill. Adm. Code 630) describes categories of maternal and child health services project activity that are eligible for funding. Requirements for Maternal and Child Health (MCH) Project grant applications are included in 77 Ill. Adm. Code 630.80 through 630.200.~~

12) Funds ~~will~~ available to the Department for funding of regional perinatal networks may be awarded to Regional Perinatal Networks under the following mechanisms:

A) The Department ~~will~~ may provide grants to designated APCs Perinatal Centers responsible for the administration and implementation of the Department's regionalized perinatal health care program. Under this option, the APC "Perinatal Center" is the applicant for Maternal and Child Health (MCH) Project funds and will apply as specified in the Department of Human Services' Maternal and Child Health Services Code (77 Ill. Adm. Code 630.30 through 630.70).

B) ~~The Department may provide grants to regional perinatal networks acting through a Regional Perinatal Management Group representing all participants in the regional network for systems management and perinatal services, including providers of preconceptional, prenatal, and family follow-up care, as well as providers of hospital-based perinatal care services. Under this option the "Regional Perinatal Management Group" is the applicant for MCH Project funds and will apply as specified in 77 Ill. Adm. Code 630 and this Part.~~

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- ~~BC)~~ Grant applications by regional perinatal networks may include services and responsibilities assigned to ~~APCs~~~~Perinatal Centers~~ and Level III ~~hospitals~~~~facilities~~ in Section 640.40(c) of this Part in addition to the perinatal care services included in 77 Ill. Adm. Code 630.30 through 630.70.
- ~~D)~~ ~~The Department may reimburse Perinatal Centers, providers of high-risk services at Level III facilities and health care agencies providing follow-up services where no local health department exists through contracts developed directly with these agencies, institutions and individuals for costs incurred in providing perinatal care services.~~
- 23) Preventive Services
- ~~A)~~ A portion of funds available to the Department for funding regional perinatal networks shall be targeted for ~~preventive services~~~~Preventive Services~~. ~~These funds may be distributed or allocated to perinatal centers or regional perinatal networks according to a needs-based formula. The formula for determining the Preventive Services allocation is based upon the following need factors:~~
- ~~i)~~ ~~Number of live births by Regional Perinatal Network~~
  - ~~ii)~~ ~~Fetal death rate by Regional Perinatal Network (Number of fetal deaths per 1,000 live births plus fetal deaths)~~
  - ~~iii)~~ ~~Low birthweight rate by Regional Perinatal Network (Number of live births less than 2500 grams per 1,000 live births)~~
  - ~~iv)~~ ~~Low or no prenatal care rate by Regional Perinatal Network (Number of live births to females receiving prenatal care during the third trimester or no care per 1,000 live births)~~
  - ~~v)~~ ~~Number of hospitals in Regional Perinatal Network~~
- ~~B)~~ ~~The rates, based on occurrences at hospital of birth are calculated~~

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~~for each Regional Perinatal Network using vital statistics for the latest three years combined for which data is available. Total live births for these years also are considered. The most current Regional Perinatal Network affiliation is used to aggregate the occurrences and determine the number of hospitals in each network.~~

- ~~C) The formula gives equal importance to each of the five need factors. Higher rates and absolute numbers indicate greater need. The values of each factor for each Regional Perinatal Network are standardized (Z-scores),\* transformed into stanine scores,\*\* and summed. The sum represents each Regional Perinatal Network's need indicator score. The indicator score is summed across all networks, and each network's relative proportion to that total is computed.~~
- ~~D) The resulting percentage for each Regional Perinatal Network is applied to the total Preventive Services funds available to determine the allocation for each Regional Perinatal Network.~~
- ~~E) \* denotes Standardized Score (z Score)~~

$$z = \frac{X - \bar{X}}{\text{s.d.}}$$

~~Where z = The standardized score for a particular perinatal network on a particular need factor~~

~~X = The rate/number for a particular perinatal network on a particular need factor~~

~~$\bar{X}$  = The mean for a particular need factor~~

~~s.d. = The standard deviation for a particular need indicator \*\* denotes Transformation of Z-scores to stanines.~~

~~Greater than + 1.75 = 9  
+1.75 to + 1.5 = 8~~

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<del>+1.25</del>	<del>to</del>	<del>±</del>	<del>0.25</del>	<del>=</del>	<del>7</del>
<del>+0.75</del>	<del>to</del>	<del>±</del>	<del>0.25</del>	<del>=</del>	<del>6</del>
<del>+0.25</del>	<del>to</del>	<del>-</del>	<del>0.75</del>	<del>=</del>	<del>5</del>
<del>-0.25</del>	<del>to</del>	<del>-</del>	<del>1.25</del>	<del>=</del>	<del>4</del>
<del>-0.75</del>	<del>to</del>	<del>-</del>	<del>1.75</del>	<del>=</del>	<del>3</del>
<del>-1.25</del>	<del>to</del>	<del>-</del>	<del>1.75</del>	<del>=</del>	<del>2</del>
<del>less</del>	<del>than</del>	<del>-</del>	<del>1.75</del>	<del>=</del>	<del>1</del>

~~(Guilford and Fruchter Fundamental  
Statistics in Psychology and Education.  
New York: McGraw-Hill)~~

- 4) ~~Requirements for Perinatal Centers and Level III facilities are included in Section 640.40(e) of this Part and include standards for medical eligibility for services.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

### Section 640.85 Exceptions to Part 640

- a) A hospital may request an exception to the standards of care set forth in this Part in accordance with this Section. Exceptions are not intended to circumvent Level designations. The hospital or the APC may seek the advice and consultation of the Department, as well as the PAC, in regard to the requirements for an exception.
- b) Exceptions to the standards of care set forth in this Part may be granted when the hospital requesting an exception demonstrates that the resources and quality of care (outcomes) are substantially equivalent to the resources and quality of care for a facility at the next highest level of designation, as indicated by the resource requirements set forth in this Part. If the hospital and its APC agree on the proposed exception, a proposed letter of agreement shall be submitted to the Department for review and approval. The Department's review will be based on compliance with this Part, patient care needs, current practice, outcomes, and geography in the regional perinatal network.
- c) If the hospital and its APC do not agree on any aspect of the proposed exception, the hospital or the APC shall consult the Subcommittee on Facility Designation (SFD) of the PAC.

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- d) The following information shall be submitted to the SFD:
- 1) A proposed letter of agreement (unsigned);
  - 2) The curriculum vitae for all directors of patient care, i.e., obstetrics, neonatal, nursing (obstetrics and neonatal);
  - 3) Appendix A of this Part (fully completed); and
  - 4) A letter from the APC that includes the following information:
    - A) The exceptions being requested;
    - B) Information demonstrating that the quality of care (outcomes) of the hospital is substantially equivalent to the standards of this Part for the next highest level of designation for the proposed exceptions;
    - C) A description of the monitoring system used when consultation between the attending physician at the hospital and the physician consultant at a higher level hospital determines that a mother or newborn infant should remain in the hospital rather than being transferred to the higher level hospital;
    - D) A description of any arrangements made between the hospital and the APC to seek or ensure quality improvement;
    - E) A copy of the hospital's Maternity and Neonatal Service Plan (Subpart O of the Illinois Hospital Licensing Requirements); and
    - F) The PAC's recommendation concerning the exception.
- e) The medical co-directors of the APC (or their designees) and the medical directors of obstetrics and maternal and newborn care and a representative of hospital administration from the applicant hospital shall participate (either in person or electronically) in the SFD's review of the application.
- f) Exceptions agreed to between hospital and the SFD shall be defined in a proposed letter of agreement and submitted to the Department for review and approval.

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The Department's review will be based on compliance with this Part, patient care needs, current practice, outcomes, and geography in the regional perinatal network.

- g) If the SFD is not able to make a decision on the exception, the SFD shall submit the request for an exception to the Department, including all of the information submitted to the SFD in accordance with subsection (d) and the SFD's recommendation concerning the exception.
- h) The Director of Public Health shall make the final decision regarding approval of the exception and the letter of agreement. The Director's decision shall be based upon the recommendations of the APC and the SFD and the documentation required in subsection (d) to determine the facility's compliance with this Part. The Director's decision may be appealed in accordance with Section 640.45. The Department shall inform the hospital, the APC and the SFD of the decision.

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.90 State Perinatal Reporting System**

- a) Purpose  
The Department will maintain a State Perinatal Reporting System to follow selected high-risk perinatal patients; to ~~ensure~~insure that those patients are assessed at appropriate intervals, receive intervention as needed, and are referred for needed support services.
- b) Identification and Referral of High-~~Risk~~risk Maternal Patients-
- 1) Each designated ~~APC Perinatal Center~~ and Level III ~~hospital facility~~ that~~which~~ provides obstetrical care shall establish criteria and procedures for identifying high-risk pregnant and postpartum patients. A statement describing ~~the~~such criteria and procedures shall be on file and shall be provided to the Department on request.
  - 2) ~~Each designated Perinatal Center and Level III facility shall prepare and distribute a Maternal Discharge Record (see Appendix C), to be provided by the Department, for each high-risk pregnancy or postpartum patient treated in the facility who requires public health nursing follow-up. If a patient is readmitted during the same or subsequent pregnancies and is~~

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~~deemed to be high risk, another Maternal Discharge Record shall be prepared and distributed if public health nursing follow-up is needed.~~

- ~~23) The hospital's Perinatal Review Committee ~~established pursuant to Section 640.70~~, or other committee established for the purpose of internal quality control or medical study for the purpose of reducing morbidity or mortality or improving patient care, shall collect and submit the ~~required~~ information required in subsection (b)(1) to the Department. These data will be considered confidential under Section 8-2101 of the Code of Civil Procedure ~~[735 ILCS 5/8-2101]~~.~~
- ~~4) The Maternal Discharge Record shall be completed and distributed within seven days after the patient's discharge from the facility. Instructions for proper completion of the Maternal Discharge Record are contained in Appendix C. Additional pages may be attached when there is insufficient space on the form for all needed information.~~
- ~~5) Copies of the Maternal Discharge Record shall be distributed as follows:~~
  - ~~A) The original form (white copy) of the Maternal Discharge Record shall be sent to the Department of Public Health, 535 West Jefferson, Springfield, Illinois 62761;~~
  - ~~B) The yellow copy shall be sent to the Local Health Department or other local health agency designated by the Department to provide follow-up services in the county or area in which the patient resides;~~
  - ~~C) The pink copy shall be retained by the reporting facility.~~
- ~~6) The hospital staff is encouraged to contact the designated local health agency by telephone when there is a need for additional information to be communicated to the local health nurse, or when a pre-discharge visit by the local health nurse is needed.~~
- ~~7) The Department will provide to the hospitals a list of Local Health Departments and other local health agencies designated to provide follow-up services to high-risk maternal patients. The list will be updated as needed, at least annually.~~

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## c) Identification of Perinatal Patients

- 1) ~~All~~ ~~The Department requires that all~~ Illinois hospitals licensed to provide obstetrical and newborn services shall report information on all perinatal patients. The Department requests, but does not require, reports on perinatal patients from hospitals outside Illinois, ~~except the (The Department does request reports from the~~ St. Louis ~~APCs~~ ~~perinatal centers~~ ~~or, and~~ hospitals maintained by the federal government ~~Federal Government~~ or other governmental agencies within the United States.)
- 2) Each hospital ~~shall~~ will prepare a Perinatal Report record (see Appendix II), to be provided by the Department, for patients meeting one of the following conditions:
  - A) Live-birth; ~~or~~
  - B) Diagnosed prior to discharge from newborn hospitalization as a perinatal or neonatal death.
- 3) ~~AGENCY NOTE:~~ Women ~~who~~ that present with spontaneous abortion, ectopic pregnancy or ~~hydatidiform~~ hydatid mole are perinatal patients and ~~shall~~ must be reported. ~~The~~ In addition, the products of induced abortions shall not be reported to the State Perinatal Reporting System.
- 4) ~~AGENCY NOTE:~~ Fetal death (gestation greater than 20 weeks) is considered a reportable perinatal outcome. ~~These and will be included in the Perinatal Reporting System. However,~~ fetal deaths do not have to be reported through the State Perinatal Reporting System, because ~~they~~ these ~~deaths~~ are already reported and compiled in the Department's ~~Departments's~~ Vital Records database.
- 53) Every hospital shall provide representatives of the Department with access to information from all medical, pathological, and other ~~pertinent~~ records and logs related to reportable registry information. The mode of access and the time during which this access will be provided shall be by mutual agreement between the hospital and the Department.
- 64) The State Perinatal Reporting System also will be complemented with

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information from the Department's Vital Records live birth database under the Vital Records Act ~~[410 ILCS 535]~~, the Adverse Pregnancy Outcomes Reporting System under the Illinois Health and Hazardous Substances Registry Act ~~[410 ILCS 525]~~ and other Maternal and Child Health Reports and submissions.

75) The State Perinatal Reporting System consists of two forms of reporting. This reporting shall be on the forms provided by the Department or through electronic means that meets the exact specifications of the Department's data processing system. Complete perinatal reporting information shall~~must~~ be reported to the Department within 14 days after infant discharge, regardless of the method of reporting.

6) ~~The Perinatal Report record shall be distributed in the following manner:~~

A) ~~Two copies of the Perinatal Reporting System record must be sent to the Department of Public Health's Office of Epidemiology and Health Systems Development, 605 West Jefferson, Springfield, Illinois 62761.~~

B) ~~A pink copy may be retained by the reporting facility.~~

C) ~~A copy must be forwarded to the Local Health Nurse.~~

D) ~~A copy must be forwarded to the Primary Care Physician.~~

d) Report of Local Health Nurse

1) ~~The Local Health Department or other designated local health agency providing follow-up services to high-risk infants shall prepare and distribute a Report of Local Health Nurse for each visit made; a Report shall also be distributed when a case is closed without a visit.~~

2) ~~Copies of the Report of Local Health Nurse shall be distributed as follows:~~

A) ~~The original form (white copy) of the Report of Local Health Nurse shall be sent to the Department of Public Health, 535 West Jefferson, Springfield, IL 62761.~~

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- B) ~~The canary copy shall be sent to the hospital which referred the patient for follow-up services.~~
  - C) ~~The pink copy shall be retained at the appropriate Local Health Nurse Agency.~~
  - D) ~~The goldenrod copy shall be sent to the patient's primary care physician.~~
- 3) ~~The Local Health Department or other designated local health agency providing follow-up services to high-risk pregnant and postpartum women should send a copy of the progress notes to the referring hospital.~~

de) Availability of Information

- 1) The patient and ~~hospital facility~~-identifying information submitted to the Department or ~~certified~~ local health ~~department agency~~ under the Act and this Part shall be privileged and confidential and shall not be available for disclosure, inspection or copying under the Freedom of Information Act or the State Records Act, except as described in this Section. These data shall also be considered confidential under Section 8-2101 of the Code of Civil Procedure.
- 2) Aggregate ~~summaries summary~~ and reports of follow-up activities may be provided upon request to hospitals, to ~~APCs Perinatal Centers~~, and to the ~~certified~~ local health ~~department agency~~ designated by the Department to provide follow-up services to the patients. ~~These Such~~ reports may contain information provided by the referring hospital and information provided by the follow-up ~~certified local health department agency~~. Patient or ~~hospital facility~~ specific data provided to the appropriate designee under this Section ~~are~~ confidential and shall be handled in accordance with ~~the provisions of~~ the Illinois Health Statistics Act ~~[410 ILCS 520]~~ and Section 9 of the Hospital Licensing Act ~~[210 ILCS 85/9]~~. These data shall also be considered confidential under Section 8-2101 of the Code of Civil Procedure ~~[735 ILCS 5/8-2101]~~.
- 3) All reports issued by the Department in which the data ~~are~~ aggregated so that no patient or reporting ~~hospital facility~~ may be identified shall be available to the public pursuant to Access to Public Records of the

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~~Department of Public Health~~ ~~the Department's Freedom of Information rules (2 Ill. Adm. Code 1126)~~ and the Freedom of Information Act ~~[5 ILCS 140].~~

- ~~e)~~ Quality Assurance and Continuous Quality Improvement
- 1) Reporting ~~entities~~ facilities (i.e., hospitals, certified local health departments ~~Local Health Departments~~, and managed care entities (MCEs ~~MCE~~), and designated local health agencies) shall be subject to review by the Department to assess the timeliness, correctness and completeness of the reports submitted by the entity ~~facility~~.
  - 2) Reporting ~~entities~~ facilities (i.e., hospitals, certified local health departments ~~Local Health Departments~~ and MCEs, ~~managed care entities (MCE)~~, and designated community health agencies) shall supply additional information to the Department at the Department's request when additional information is ~~when~~ needed to confirm the accuracy of reports previously submitted, or to clarify information previously submitted. The Department will ~~shall~~ not request data that are more than two years old.
  - 3) ~~Monthly reports will be compiled by the Department, listing all hospital referrals to each health department/agency. The reports will be used for audits and assistance to health departments.~~
  - 4) ~~Managed Care Entities must submit their Quality Assurance Plan (QAP) to the Department for review and use in state-wide Quality Improvement in Perinatal program efforts.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

**Section 640.100 High-Risk Follow-up Program**

The Illinois Department of Human Services manages the high-risk follow-up program in accordance with the Maternal and Child Health Services Code (77 Ill. Adm. Code 630).

- a) ~~Local Health Nursing Follow-up for the High-Risk Mother~~
- 1) ~~Purpose~~  
~~Home visits to families of high-risk/pregnant and postpartum women have~~

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~~a two-fold purpose: assessment of the woman and the family/environment and facilitation of early intervention for identified problems.~~

2) ~~Agencies to Provide Services~~

A) ~~All Local Health Departments should provide follow-up services to residents of their counties.~~

B) ~~The Department may contract with a local health agency or county nurse to provide follow-up services to residents of areas without a Local Health Department.~~

3) ~~Eligibility for Services~~

~~Any pregnant or postpartum patient identified as high-risk by a Level III hospital and referred to a Local Health Department or other designated local health agency should be offered follow-up services. The patient may decline such services.~~

4) ~~Services to be Provided~~

A) ~~Home visits to high-risk pregnant women should be scheduled as often as the client's condition warrants or as requested by the attending physician. A post-discharge visit should be made as soon as possible after discharge. Additional visits may be made during the postpartum period (i.e., 6 weeks following the date of delivery) for pregnancy-related conditions as indicated or as requested by the attending physician. If additional visits are for chronic health conditions (e.g., chronic hypertension, CVA, advanced cardiac disease), the patient should be referred to the licensed home health agency in the area for long-term follow-up.~~

B) ~~Local health agencies which provide services must adhere to the provisions of the Maternal and Child Health Services Code (77 Ill. Adm. Code 630).~~

b) ~~Local Health Nursing Follow-up for High-risk Infants~~

1) ~~Purpose~~

~~The purpose of the infant follow-up program is to minimize disability in~~

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~~high-risk infants by identifying as early as possible conditions requiring further evaluation, diagnosis, and treatment and by assuring an environment that will promote optimal growth and development.~~

2) ~~Agencies to Provide Services~~

~~A) All Local Health Departments should provide follow-up services to residents of their counties.~~

~~B) The Department may contract with a local health agency to provide follow-up services to residents of areas without a Local Health Department.~~

3) ~~Eligibility for Services~~

~~Any infant eligible for the Adverse Pregnancy Outcomes Reporting System (APORS) and referred to a Local Health Department or other designated local health agency should be offered follow-up services. The family may decline such services.~~

4) ~~Services to be Provided~~

~~A) A minimum of 6 visits should be made by the follow-up nurse: as soon as possible after newborn hospital discharge, and at infant chronological ages 2, 6, 12, 18, and 24 months. Infants and their families having actual or potential health problems identified by the nurse should be visited more frequently for health monitoring, teaching, counseling and/or referral for appropriate services. Occasionally, when an infant is receiving services at the health department, a follow-up visit may be conducted by the nurse at that time.~~

~~B) Follow-up services should include:~~

~~i) Health History including: prenatal and natal history; parental concerns; family history of genetic disease or unexplained mental retardation; compliance with medical regimen, if any, including medications, treatments, and visits to the physician; infant care, including nutrition, elimination, and sleep activity; and family/infant~~

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~~interaction, family coping and parental knowledge of injury prevention.~~

- ~~ii) Physical assessment, developmental assessment, and age specific anticipatory guidance based on the American College of Obstetricians and Gynecologists guidelines or current recommendations of the State that are found in subsection (b)(5) of this Section.~~
  - ~~iii) Based on the results of the health history and physical assessment, the nurse will identify problems and nursing diagnoses and arrange for intervention. Intervention may include: counseling the family as to the importance of regular primary health care by the family physician, pediatrician, or clinic; encouraging scheduled return visits to Perinatal Center; family teaching/counseling by the follow-up nurse; referral to the physician or other screening, diagnostic or support services depending on the nature of the problem; and follow-up on referrals.~~
- ~~5) Local health agencies must adhere to the provisions of the Maternal and Child Health Services Code (77 Ill. Adm. Code 630) and the Department's High Risk Infant Tracking Supplement for Local Health Departments, which may be obtained from the Department's Office of Family Health.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX A Standardized Perinatal Site Visit Protocol**

Standardized Perinatal Site Visit Protocol

Components of site visit tool – information to be completed by applicant hospital prior to site visit and reviewed and approved at time of site visit by site visit team.

HOSPITAL: \_\_\_\_\_ CITY: \_\_\_\_\_, Illinois

Level of Designation Applied for: Level I \_\_\_\_\_ Level II \_\_\_\_\_ Level II with Extended Neonatal Capabilities \_\_\_\_\_ Level III \_\_\_\_\_ Administrative Perinatal Center \_\_\_\_\_

ADMINISTRATIVE PERINATAL CENTER: \_\_\_\_\_

DATE OF SITE VISIT: \_\_\_\_\_

GEOGRAPHIC AREA SERVED (Provide description):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEMBERS (titles and affiliated institutions) OF SITE VISIT TEAM:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I. HOSPITAL DATA**

Please use data from most recent three calendar years

**A. MATERNAL DATA**

	<u>200</u>	<u>200</u>	<u>201</u>	
<u>1. Number of Obstetrical Beds:</u>				<u>Current RN/Patient ratio</u>
<u>a. Ante-partum</u>				
<u>b. Labor / Delivery LDR</u>				
<u>C/Section Rooms</u>				
<u>Delivery Rooms (LDR, see above)</u>				
<u>c. LDRP</u>				

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<u>d. Pospartum</u>				<u>(mother/baby couplets)</u>
<u>2. Total Number of Women Delivering</u>				
<u>3. Number of Vaginal Deliveries:</u>				
<u>Spontaneous</u>				
<u>*Forceps</u>				
<u>*Vacuum Extraction</u>				
<u>4. Number of C/Sections – add percents-#/%</u>				
<u>Total</u>	<u>/%</u>	<u>/%</u>	<u>/%</u>	
<u>Primary</u>	<u>/%</u>	<u>/%</u>	<u>/%</u>	
<u>Repeat</u>	<u>/%</u>	<u>/%</u>	<u>/%</u>	
<u>5. Number of Vaginal Births After Cesarean (VBAC) – add percent – #/%</u>				
<u>6. Number of inductions</u>				
<u>+7. Number of augmentations</u>				

\* Use final delivery modality

+ Augmentation – stimulation of contractions when spontaneous contractions have failed to progress dilation or descent

**B. NEONATAL DATA**

<u>1. Number of nursery beds:</u>	<u>200</u>	<u>200</u>	<u>201</u>	<u>Current RN/Patient Ratio</u>
<u>Normal newborn</u>				
<u>Intermediate/Special care</u>				
<u>NICU/Level III only</u>				
<u>2. Average daily census in the Special Care Nursery* (Level II or II with extended neonatal capabilities)</u>				

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<u>3. Average daily census in the NICU (Level III only)</u>				
---	--	--	--	--

\* Provide explanation of how average daily census in Special Care Nursery was calculated.

**C. LIVE BIRTH DATA**

1. Birth Weight Specific Data – indicate # born & died in each category (example 10/2)  
(Use Electronic Birth Certificate data for live births) (add percent for LBW and VLBW in shaded areas)

	<u>200</u>	<u>200</u>	<u>201</u>
<u>&lt; 500 grams</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>500 – 749</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>750 – 999</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>1000 – 1249</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>1250 – 1499</u>	<u>/</u>	<u>/</u>	<u>/</u>
<b><u>Percent for VLBW</u></b>			
<u>1500 – 1999</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>2000 – 2499</u>	<u>/</u>	<u>/</u>	<u>/</u>
<b><u>Percent for LBW</u></b>			
<u>2500 – 2999</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>3000 – 3499</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>3500 – 3999</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>4000 – 4499</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>4500 – 4999</u>	<u>/</u>	<u>/</u>	<u>/</u>
<u>5000 Plus</u>	<u>/</u>	<u>/</u>	<u>/</u>
<b><u>Total Live Births/Neonatal Deaths</u></b>			

2. Incidence of Neonatal complications (Occurrences at hospital of birth)

<u>Use &lt;1500 gram VON data</u>	<u>200</u>	<u>200</u>	<u>201</u>
<u>Necrotizing enterocolitis</u>			

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<a href="#">Retinopathy of prematurity</a>			
<a href="#">Intraventricular hemorrhage – Grade III</a>			
<a href="#">Grade IV</a>			
<a href="#">Peri-ventricular leukomalacia</a>			
<a href="#">Broncho-pulmonary dysplasia</a>			
<b><a href="#">*Use all babies for categories below</a></b>			
<a href="#">Respiratory Distress Syndrome (ICD 9 code 769)</a>			
<a href="#">Persistent Pulmonary Hypertension of the Newborn (ICD 9 code 747.83)</a>			
<a href="#">Meconium Aspiration Syndrome (ICD 9 code 770.1)</a>			
<a href="#">Neonatal Surgeries</a>			
<a href="#">Seizures (ICD 9 code 779.0)</a>			
<a href="#">Infections (7 ICD 9 code 771.81)</a>			
<a href="#">5 minute Apgar &lt;7 (exclude infants &lt;500 grams)</a>			

**[\\* If in expanded VON, use VON data for "all babies" categories](#)**

**D. FETAL DEATHS**

[Birth weight Specific Data – # per weight category](#)

	<a href="#">200</a>	<a href="#">200</a>	<a href="#">201</a>
<a href="#">&lt;500 grams</a>			
<a href="#">500 – 749</a>			
<a href="#">750 – 999</a>			
<a href="#">1000 – 1249</a>			
<a href="#">1250 – 1499</a>			
<a href="#">1500 – 1999</a>			

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<a href="#">2000 – 2499</a>			
<a href="#">2500 – 2999</a>			
<a href="#">3000 – 3499</a>			
<a href="#">3500 – 3999</a>			
<a href="#">4000 – 4499</a>			
<a href="#">4500 – 4999</a>			
<a href="#">5000 Plus</a>			
<b><a href="#">Total Fetal Deaths</a></b>			

**E. MORTALITY DATA**

	<a href="#">200</a>	<a href="#">200</a>	<a href="#">201</a>
<a href="#">1. Maternal Deaths (Hospital of Delivery) (attach table with individual dispositions, factors and cause of death) Pregnancy Related Non-pregnancy Related</a>			
<a href="#">2. Perinatal Deaths (attach summary table with dispositions and factors per year for 3 years) a. <a href="#">Fetal Deaths (FD)</a> b. <a href="#">Neonatal Deaths (ND)</a></a>			
<a href="#">*3. Mortality Rates (all births) a. <a href="#">Fetal Mortality Rate (FD/total births X 1000)</a> b. <a href="#">Neonatal Mortality Rate (ND/total live births X 1000)</a> c. <a href="#">Perinatal Mortality Rate (FD + ND/total births X 1000)</a> d. <a href="#">Vermont Oxford Standard Mortality Rate</a></a>			

[\\* Question #3, only for Level III institutions](#)

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**F. TRANSPORT DATA**

	<u>200</u>	<u>200</u>	<u>201</u>
<u>1. Number of maternal transfers/transports/transports (Do not include return transfers/transports )</u>			
<u>Into institution</u>			
<u>Out of institution</u>			

	<u>200</u>	<u>200</u>	<u>201</u>
<u>2. Number of neonatal transfers (Do not include return transfers/transports)</u>			
<u>Into institution</u>			
<u>Out of institution</u>			

3. Provide maternal and neonatal transport information for the most current calendar year (for Perinatal Centers, provide transport information by hospital, by gestational age and by year for 3 years).

**II. OB HEMORRHAGE DOCUMENTATION**

List OB Hemorrhage cases from the previous calendar year (patients sent to ICU or received 3 or greater units of blood products).

**III. RESOURCE REQUIREMENTS**

Complete attached Resource Checklist for the appropriate level of care – current level and level being applied for if different.

**IV. ADMINISTRATIVE PERINATAL CENTERS**

- A. Provide documentation of educational activities sponsored by the Administrative Perinatal Center for network hospitals and local health departments.
- B. Provide evidence of morbidity and mortality reviews with network hospitals.
- C. Provide written documentation of Regional Perinatal Network CQI Activities.

Components of site visit tool—information to be completed by applicant facility prior to site visit and reviewed and approved at time of site visit.

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~~(By site visit team)~~

~~Initial/Date~~

**I. PROGRAM DOCUMENTATION:**

~~/ Updated maternity service plan with current staffing pattern appropriate for level of care.~~

~~/ Documentation of orientation program for nursing staff.~~

~~/ Documentation of ongoing continuing education program.~~

~~/ Documentation of Continuous Quality Improvement (CQI) Activities.~~

~~/ Updated, comprehensive procedure manual.~~

~~/ Appropriate resources checklist.~~

**II. STAFF PERFORMANCE:**

~~/ Chart review (site visit team).~~

~~/ Discussion of patient care with staff selected at random by the site visit team.~~

**III. COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

~~Director of Site Visit Team:~~ \_\_\_\_\_

~~Title:~~ \_\_\_\_\_

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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Section 640.APPENDIX B Outcome Oriented Data: Perinatal Facility Designation/  
Redesignation (Repealed)

Section 640.EXHIBIT A Outcome Oriented Data Form (Repealed)

Level of Designation Applied for: Level I \_\_\_\_ Level II \_\_\_\_  
Level II (with extended capabilities) \_\_\_\_  
Level III \_\_\_\_ Perinatal Center \_\_\_\_

HOSPITAL: \_\_\_\_\_ CITY: \_\_\_\_\_

DESCRIPTION OF GEOGRAPHIC AREA SERVED: \_\_\_\_\_

PERINATAL CENTER: \_\_\_\_\_ DATE OF SITE VISIT: \_\_\_\_\_

MEMBERS (titles and affiliated institution) OF SITE VISIT TEAM: \_\_\_\_\_

Please use data from previous 3 calendar years: YEAR \_\_\_\_\_

I. STATISTICS

A. Maternal Data

- 1. Number of obstetrical beds:
  - a. Antepartum \_\_\_\_\_
  - b. Labor / Delivery \_\_\_\_\_
  - LDR / DRP \_\_\_\_\_
  - C/Section Rooms \_\_\_\_\_
  - Delivery Rooms \_\_\_\_\_
  - e. Intensive Care Beds \_\_\_\_\_

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	d. Postpartum	_____	_____	_____
2.	Total number of deliveries:	_____	_____	_____
3.	Percent of vaginal deliveries:			
	Spontaneous	_____	_____	_____
	Forceps	_____	_____	_____
	Vacuum Extraction	_____	_____	_____
4.	Percent of C/Sections:			
	% Primary	_____	_____	_____
	% Repeat	_____	_____	_____
5.	Number of VBACs:			
	Attempts	_____	_____	_____
	Successes	_____	_____	_____
6.	Percent of inductions:	_____	_____	_____
7.	Percent of augmentations:	_____	_____	_____
8.	Outcomes for Maternal Admissions with the following diagnosis:			
	<b>Diabetes</b>			
	# of maternal admission	_____	_____	_____
	# transferred out for delivery	_____	_____	_____
	# discharged undelivered	_____	_____	_____
	# of neonatal deaths	_____	_____	_____
	# of fetal deaths	_____	_____	_____
	# of neonates transferred to a higher level facility	_____	_____	_____
	<b>Chronic Hypertension</b>			
	# of maternal admissions	_____	_____	_____
	# transferred out for delivery	_____	_____	_____
	# discharged undelivered	_____	_____	_____
	# of neonatal deaths	_____	_____	_____
	# of fetal deaths	_____	_____	_____
	# of neonates transferred to a	_____	_____	_____

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higher level facility

\_\_\_\_\_  
\_\_\_\_\_

**B. Neonatal Data**

1. Number of nursery beds:

Normal Newborn

\_\_\_\_\_  
\_\_\_\_\_

Intermediate / Special care

\_\_\_\_\_  
\_\_\_\_\_

NICU / Level III

\_\_\_\_\_  
\_\_\_\_\_

Average daily census in the Special Care Nursery

\_\_\_\_\_  
\_\_\_\_\_

(Level II or II with extended capabilities or Level III intermediate)

Average daily census in the NICU (Level III)

\_\_\_\_\_  
\_\_\_\_\_

**C. Fetal Mortality**

1. Birthweight Specific Data:

<500 grams

\_\_\_\_\_  
\_\_\_\_\_

501-750

\_\_\_\_\_  
\_\_\_\_\_

751-1000

\_\_\_\_\_  
\_\_\_\_\_

1001-1250

\_\_\_\_\_  
\_\_\_\_\_

1251-1500

\_\_\_\_\_  
\_\_\_\_\_

1501-2000

\_\_\_\_\_  
\_\_\_\_\_

2001-2500

\_\_\_\_\_  
\_\_\_\_\_

2501-3000

\_\_\_\_\_  
\_\_\_\_\_

3001-3500

\_\_\_\_\_  
\_\_\_\_\_

3501-4000

\_\_\_\_\_  
\_\_\_\_\_

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	4001-4500	_____	_____	_____
	4501-5000	_____	_____	_____
	5001-PLUS	_____	_____	_____
	2. <del>Live Birth Data:</del>			
<del>&lt;500 grams:</del>	<del>Number of infants born</del>	_____	_____	_____
	<del>Number of infants ventilated beyond six hours</del>	_____	_____	_____
	<del>Number of ventilated infants survived</del>	_____	_____	_____
	<del>Ventilator days (total)</del>	_____	_____	_____
	<del>Oxygen days (total)</del>	_____	_____	_____
	<del>Length of stay (days)</del>	_____	_____	_____
<del>501-750 grams</del>	<del>Number of infants born</del>	_____	_____	_____
	<del>Number of infants ventilated beyond six hours</del>	_____	_____	_____
	<del>Number of ventilated infants survived</del>	_____	_____	_____
	<del>Ventilator days (total)</del>	_____	_____	_____
	<del>Oxygen days (total)</del>	_____	_____	_____
	<del>Length of stay (days)</del>	_____	_____	_____
<del>751-1000 grams:</del>	<del>Number of infants born</del>	_____	_____	_____
	<del>Number of infants ventilated beyond six hours</del>	_____	_____	_____
	<del>Number of ventilated infants survived</del>	_____	_____	_____
	<del>Ventilator days (total)</del>	_____	_____	_____
	<del>Oxygen days (total)</del>	_____	_____	_____
	<del>Length of stay (days)</del>	_____	_____	_____
<del>1001-1250 grams:</del>	<del>Number of infants born</del>	_____	_____	_____
	<del>Number of infants ventilated beyond six hours</del>	_____	_____	_____
	<del>Number of ventilated infants survived</del>	_____	_____	_____

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	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
1251-1500 grams:	Number of infants born	_____	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
1501-2000 grams:	Number of infants born	_____	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
2001-2500 grams:	Number of infants born	_____	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
2501-3000 grams:	Number of infants born	_____	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____

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3001-3500 grams:	Number of infants born	_____	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
	3501-4000 grams:	Number of infants born	_____	_____
Number of infants ventilated beyond six hours		_____	_____	_____
Number of ventilated infants survived		_____	_____	_____
Ventilator days (total)		_____	_____	_____
Oxygen days (total)		_____	_____	_____
Length of stay (days)		_____	_____	_____
4001-4500 grams:		Number of infants born	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
	Number of ventilated infants survived	_____	_____	_____
	Ventilator days (total)	_____	_____	_____
	Oxygen days (total)	_____	_____	_____
	Length of stay (days)	_____	_____	_____
	4501-5000 grams:	Number of infants born	_____	_____
Number of infants ventilated beyond six hours		_____	_____	_____
Number of ventilated infants survived		_____	_____	_____
Ventilator days (total)		_____	_____	_____
Oxygen days (total)		_____	_____	_____
Length of stay (days)		_____	_____	_____
5001 PLUS:		Number of infants born	_____	_____
	Number of infants ventilated beyond six hours	_____	_____	_____
		_____	_____	_____

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Number of ventilated infants survived	_____	_____	_____
Ventilator days (total)	_____	_____	_____
Oxygen days (total)	_____	_____	_____
Length of stay (days)	_____	_____	_____

**Incidence of Neonatal Complications:**

Pulmonary air leaks	_____	_____	_____
Necrotizing enterocolitis	_____	_____	_____
Retinopathy of Prematurity	_____	_____	_____
Intraventricular hemorrhage	_____	_____	_____
Grade I & II	_____	_____	_____
Grade III & IV	_____	_____	_____
Periventricular leukomalacia	_____	_____	_____
Bronchopulmonary dysplasia	_____	_____	_____
Neonatal Sepsis	_____	_____	_____
Respiratory Distress Syndrome	_____	_____	_____
Persistent Pulmonary Hypertension of the Newborn	_____	_____	_____
Meconium Aspiration Syndrome	_____	_____	_____
Neonatal Surgeries	_____	_____	_____
Seizures	_____	_____	_____
5-minute Apgar <7	_____	_____	_____

**D. OUTCOME STATISTICS**

All neonatal deaths are to be counted by the hospital of birth regardless of place of death. Neonates born in emergency rooms are to be counted by the hospital of birth.

- 1. **Maternal Deaths:**  
(Attach documentation of joint case review meeting and assigned disposition of mortality for each death.)
- |       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
|-------|-------|-------|

DEPARTMENT OF PUBLIC HEALTH

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~~(Standardized Neonatal Mortality Rate and Standardized Perinatal Mortality Rate. This information should be obtained from the most current Perinatal Health Status Reports.)~~

2. Standardized Neonatal Mortality Rate: \_\_\_\_\_

3. Standardized Perinatal Mortality Rate: \_\_\_\_\_  
~~(Attach documentation of joint case review meetings and assigned disposition of the mortalities. Give synopsis of action taken on deaths disposed as potentially avoidable.)~~

**H. STAFF**

A. ~~List the names and titles of directors/chairperson: Attach CV of Medical Directors; where appropriate identify subspecialty board).~~

	<i>Full Time</i>	<i>Board Certified</i>	<i>Sub-board Certified</i>
<del>Maternal—Fetal</del> _____	<del>Y/N</del>	<del>Y/N</del>	<del>Y/N</del>
<del>Neonatology</del> _____	<del>Y/N</del>	<del>Y/N</del>	<del>Y/N</del>
<del>Obstetric</del> _____	<del>Y/N</del>	<del>Y/N</del>	
<del>FP/GP</del> _____	<del>Y/N</del>	<del>Y/N</del>	
<del>Anesthesia</del> _____	<del>Y/N</del>	<del>Y/N</del>	
<del>Obstetric Anesthesia</del> _____	<del>Y/N</del>	<del>Y/N</del>	

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Pediatric _____	Y/N	Y/N	
OB/Gyn Residency Program (if applicable) _____	Y/N		
Pediatric Residency Program (if applicable) _____	Y/N		
Perinatal Fellowship Program _____	Y/N		
Neonatal Fellowship program _____	Y/N		
Pediatric Surgery _____	Y/N	Y/N	Y/N
Pediatric Neurosurgery _____	Y/N	Y/N	
Pediatric Radiology _____	Y/N	Y/N	
Pediatric Cardiology _____	Y/N	Y/N	Y/N
Pediatric Cardiac Surgery _____	Y/N	Y/N	
Pediatric Anesthesiology _____	Y/N	Y/N	
Pediatric Ophthalmology _____	Y/N	Y/N	

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Pediatric Nephrology	Y/N	Y/N	Y/N
Pediatric Medical Genetics	Y/N	Y/N	
Pediatric Orthopedics	Y/N	Y/N	
Pediatric Otolaryngology	Y/N	Y/N	
Pediatric Pulmonology	Y/N	Y/N	Y/N
Pediatric Hematology	Y/N	Y/N	Y/N
Pediatric Endocrinology	Y/N	Y/N	Y/N
Pediatric Gastroenterology	Y/N	Y/N	Y/N

B: Staff Available	<i>On-Call</i>	<i>In-House 24 hours/day</i>
Obstetrics	_____	_____
Neonatology	_____	_____
OB Anesthesia	_____	_____
Maternal / Fetal	_____	_____

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C. Nursing

~~(List the names, titles, and credentials of nursing staff, as required for this section, with privileges in the Departments of Obstetrics and Pediatrics. Attach CB of Director of Nursing.)~~

~~Director of Nursing (Maternal / Child Nursing)~~

~~Director of Nursing (NICU / NBN)~~

~~Certified Nurse Midwife / Midwives~~

~~Clinical Specialist/Nurse Practitioners—Neonatal and Obstetrics~~

~~Transport Coordinators~~

~~Neonatal Y N~~

~~Maternal / Fetal Y N~~

~~Allied Health Staff~~

~~Radiology Director Y N~~

~~Genetics Director Y N~~

~~Respiratory Therapy Director Y N~~

~~Licensed Social Worker Y N~~

~~Registered Dietitian Y N~~

~~Director of Laboratory Y N~~



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~~only):~~

~~e. Number of maternal transfer patients refused and reasons for refusal:~~

~~2. Neonatal:~~

~~a. List conditions for which neonates were transferred (latest year only):~~

~~b. List hospitals to which neonates were transferred (latest year only):~~

~~c. Number of neonatal transfer patients refused and reasons for refusal (latest year only):~~

F. Anesthesia

~~1. Is 24-hour anesthesia available in house?    Y        N~~

~~If yes, who (anesthesiologist, nurse anesthetist) \_\_\_\_\_~~

~~If anesthesia is on-call, response time? \_\_\_\_\_~~

~~2. Location C/Section performed \_\_\_\_\_ in OR suite on obstetrical level  
\_\_\_\_\_ in OR suite on surgery level~~

~~3. Length of time required for start-up of C/Section \_\_\_\_\_~~

G. Education

~~1. Documentation of in-service education programming provided:    Y    N  
Brief description, dates, and attendance:~~

~~2. Documentation of fetal monitoring and neonatal resuscitation programs provided. Brief description, dates, and attendance:~~

~~3. Documentation of C/Section Reviews:~~

H. Developmental Follow-up Program

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~~Briefly describe your developmental follow-up program, and include the name of the Director of this program and the length of follow-up.~~

~~Explain arrangements for integrating Early Intervention Programs with the discharge planning process and developmental follow-up program.~~

~~I. Continuous Quality Improvement (CQI)~~

~~Briefly describe CQI Activities specific to Maternal/Fetal/Neonatal Medicine.~~

~~J. Perinatal Centers~~

- ~~1. Provide documentation of educational activities sponsored by the Center for Network hospital and community health agencies.~~
- ~~2. Provide documentation of morbidity and mortality reviews with Network hospitals.~~
- ~~3. Provide documentation of Network Continuous Quality Improvement (CQI) activities.~~

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX B Outcome Oriented Data: Perinatal Facility Designation/  
Redesignation (Repealed)**

**Section 640.EXHIBIT B Data Collection Exception Form (Repealed)**

**Sample Data Collection Form for Hospitals Serving "Exception" Cases**

~~Both maternal and neonatal data should be supplied for either a maternal or neonatal exception. However, if a maternal exception is transported to another hospital for delivery, the data relevant to the neonate will not be provided by the referring hospital.~~

Cases	Maternal Data			Neonatal Admitting Data				Neonatal Outcome			
Name and Record #s	Admission:	Maternal Dx and Risk Factors:	Perinatal Center/Level III Contact?	Birth	GA	Weight	Perinatal Center/Level III Contact?	Vent care?*	D/C Problem List/Referral and Follow-up Plan:	D/C Date	If death, H & H Disposition:
Baby	Date Time		Name Date Time	Date Time		Admitting Dx:	Name Date Time	Hours _____ or Days _____ (*positive pressure)			
Mother			Transport? Date Time To Where?	APGARS	1 min ____ 5 min ____ 10 min ____		Transport? Date Time To Where?				

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

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Section 640.APPENDIX C Maternal Discharge Record (Repealed)

Section 640.EXHIBIT A Maternal Discharge Record Form (Repealed)



State of Illinois
Department of Public Health
MATERNAL DISCHARGE RECORD
PERINATAL TRACKING SYSTEM

Form with multiple sections: REFERRING HOSPITAL AND CITY, PATIENT'S LAST NAME, HUSBAND'S LAST NAME, REPRODUCTIVE HISTORY CHECK, REASONS FOR REFERRAL, DISCHARGE DATE, BLOOD PRESSURE, HEIGHT, WEIGHT, FAMILY PLANNING, PATIENT DELIVER DURING THIS ADMISSION, TYPE & DATE OF DELIVERY, WAS INFANT AT HIGH RISK, INFANTS CONDITION, BIRTH WEIGHT, APGARS, MAJOR TREATMENT OF MOTHER, OTHER CONCERNS.

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PHYSICIAN PROVIDING FOLLOW-UP CARE:*(INC. ADDRESS & PHONE #)		HOSPITAL NURSE CONTACT	TELEPHONE
REFERRAL TO COMMUNITY SERVICES* <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES TO: <input type="checkbox"/> WIC <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> SOCIAL SERVICE AGENCY <input type="checkbox"/> PRENATAL ED <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> DCFS <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____		
CONTACT PERSON'S NAME	RELATIONSHIP TO PATIENT*	TELEPHONE NUMBER* (____) _____	
STREET ADDRESS	CITY	STATE	ZIP CODE
2 <sup>ND</sup> CONTACT PERSON'S NAME	RELATIONSHIP TO PATIENT	TELEPHONE NUMBER* (____) _____	
PATIENT INFORMED OF PUBLIC HEALTH NURSE VISIT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PUBLIC HEALTH NURSE AGENCY NAME	CODE	ADDRESS

SEND ORIGINALS: DEPARTMENT OF PUBLIC HEALTH  
535 WEST JEFFERSON  
SPRINGFIELD, IL 62761

SIGNATURE\* \_\_\_\_\_

COPIES: YELLOW LOCAL HEALTH NURSE    PINK FACILITY  
IL444-4210 (N-10-98)

DATE\* \_\_\_\_\_

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX C Maternal Discharge Record (Repealed)**

**Section 640.EXHIBIT B Instructions for Completing Maternal Discharge Record (Repealed)**

The following Section describes the data elements to complete the Maternal Discharge Record.

~~Medicaid Recipient Number: Enter client's existing Medicaid recipient number.~~

~~Medicaid Pending: Check box (yes) if Medicaid has been applied for and is pending.~~

~~Social Security Number: Enter clients social security number.~~

~~Referring Hospital Name and City: Enter the name and city of the discharging hospital.~~

~~Hospital Code: Enter the code of the referring hospital.~~

~~Medical Record Number: Enter the patient number used by your hospital which number is unique to this patient. This number is usually assigned by the business office.~~

~~Cornerstone Number: IDPH/Local Health Agency use.~~

~~Date of Admission: Enter the date the patient was admitted to the hospital.~~

~~Race: Check the appropriate box. If a patient does not consider herself as belonging to any of the three racial groups, type or write the preferred designation alongside "Race."~~

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Hispanic:	Check the appropriate box. Indicate "Hispanic" if the patient identifies herself with that ethnic group. NOTE: Mark both "Race" and "Hispanic" for all Hispanic patients. Hispanic persons may belong to any race.
County of Residence:	Print the name of the county in which the patient resides.
County Code:	Enter the county code, if known.
Patient's Last Name, First Name, M.I.:	Print the name of the patient.
Date of Birth:	Enter the birth date of the patient.
Husband's Last Name, First Name:	Print the name of the patient's husband if she is married.
Patient's Maiden Name:	Print the maiden name of the patient. Enter the maiden name even when it is identical with the last name.
Marital Status:	Check the appropriate box.
Patient's Telephone Number:	Enter the Patient's home telephone number, including area code.
Patient's Street Address:	Enter apartment number, if any, house number, street, city, state and zip code of the patient.
Gravida:	Enter the total number of pregnancies, including the present pregnancy.

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<del>Para:</del>	<del>F: Number of full term births P: Number of premature births A: Number of abortions, spontaneous and induced L: Number of living children</del>
<del>Blood Type:</del>	<del>Enter the blood group (O, A, B, or AB) and the RH type (positive or negative).</del>
<del>HbsAG Status:</del>	<del>Indicate positive or negative for hepatitis B surface antigen. When positive, or reactive, indicates HBV infected at the present time with the ability to pass the disease to other people.</del>
<del>EDC:</del>	<del>Enter the estimated month, day, and year of confinement.</del>
<del>Prenatal Care Began:</del>	<del>Enter the number of completed weeks of gestation at which the patient began prenatal care. If prenatal records are not available, enter the estimated weeks of gestation based on patient recall.</del>
<del>Prenatal Visits:</del>	<del>Enter the total number of prenatal visits the patient had.</del>
<del>Reproductive History:</del>	<del>Check the box or boxes for all items that apply.</del>
<del>Reasons for Referral:</del>	<del>Check the box or boxes for all items that apply.</del>
<del>Discharge Date:</del>	<del>Enter the month, day, and year the patient was discharged from the hospital.</del>
<del>Blood Pressure:</del>	<del>Enter the blood pressure of the patient at discharge.</del>

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<del>Height:</del>	<del>Enter the height in feet and inches of the patient.</del>
<del>Weight:</del>	<del>Enter the weight in pounds of the patient at discharge.</del>
<del>Family Planning:</del>	<del>Check the appropriate box.</del>
<del>Patient Delivered During This Admission:</del>	<del>Check the appropriate box.</del>
<del>Type and Date of Delivery:</del>	<del>If the patient delivered during this admission, indicate the date of delivery and whether the delivery, was a vaginal delivery, caesarean section, or other, i.e., ectopic, hydatidiform mole.</del>
<del>Was Infant High Risk:</del>	<del>If the patient delivered during this admission, indicate whether the infant required care other than normal newborn.</del>
<del>Infant's Condition:</del>	<del>If the patient delivered during this admission, indicate the infant's sex, birth weight and APGAR scores.</del>
<del>Major Treatment During Hospitalization:</del>	<del>List all major medical and/or surgical treatments that the patient underwent while hospitalized (i.e., C-Section, mechanical ventilation, etc.).</del>
<del>Discharge Treatments/ Diagnosis/Medications:</del>	<del>Briefly describe any treatments and medications (i.e., prescriptions, diet, restricted activity) prescribed for the patient at discharge.</del>
<del>Other Concerns:</del>	<del>Enter any additional information that may assist the local health nurse in providing appropriate follow-up services to this patient.</del>

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Physician Providing Follow-up Care:	Physician providing follow-up care to mother, include address and telephone number.
Hospital Nurse Contact:	Enter name and telephone number of hospital nurse who can answer questions, if necessary.
Referral to Community Services:	If the patient has been referred to any community service agency, check appropriate box(es).
Contact Person's Name:	Print the name of a friend, relative or other person with a stable address who would know how to get in touch with the patient.
Relationship:	Describe the relationship (friend, mother, pastor, etc.) of the contact person to the patient.
Telephone Number:	Enter the telephone number of the contact person.
Street Address, City, Zip Code:	List the complete address of the contact person.
Second Contact Person, Relationship and Telephone Number:	Print name of another contact person who lives at a different address than above. Include name, relationship, and telephone number.
Patient Informed of LHN Visit:	If the patient has been informed that a local public health nurse will visit her home, check the "Yes" box, otherwise check the "No" box.

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~~Local Health Nurse Agency Name:~~ Enter the name of the local health nurse agency to which the patient was referred for follow-up services. The Department will provide a list of the agencies and the areas they serve.

~~Local Health Nurse Agency Code:~~ Enter code.

~~Street Address, City, Zip Code:~~ Complete address of LHN agency.

~~Signature:~~ The person completing the medical information should sign the form.

~~Date:~~ Enter date the form is completed.

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX F Report of Local Health Nurse, Infant (Repealed)**

**Section 640.EXHIBIT A Local Health Nurse, Infant Form (Repealed)**

Infant Report		Report of Local Health Nurse—Illinois Department of Public Health			
Infant, Last Name	Infant, First Name	Sex M/F/U	Birth date /—/	Cornerstone I.D.#	
Patient I.D.#	Infant Classification <input type="checkbox"/> APORS <input type="checkbox"/> Genetics <input type="checkbox"/> Both				
Street Address		Apt. No.	City		Zip Code
Local Health Agency			Agency Code _____		
Hospital of Delivery		Reporting Hospital		Reporting Hospital Code _____	
Chronological Age <input type="checkbox"/> <input type="checkbox"/> wks. <input type="checkbox"/> <input type="checkbox"/> mos.		Corrected Age <input type="checkbox"/> <input type="checkbox"/> wks. <input type="checkbox"/> <input type="checkbox"/> mos.			
Mother, Last Name		Mother, First Name		Mother, Maiden Name	
Date of Visit —/—/	Visit No. 0 1 2 3 4 5 6 7 8 9 10				
Date Case Closed —/—/	Case Closed		<input type="checkbox"/> With Visit		<input type="checkbox"/> Without Visit
Reason for Closure (Circle One)	1. Completed Program		4. Refused Visit		7. Other _____
	2. Infant Died		5. Services No Longer Needed		_____
	3. Unable to Locate		6. Moved		_____
Discharge/Diagnoses/Additional: (Please Print)		ICD-9 Code (for IDPH use only)		Drug Toxicity — If yes, check all that apply:	
1. _____		_____		<input type="checkbox"/> 0 Opioid <input type="checkbox"/> 4 Mixed	
2. _____		_____		<input type="checkbox"/> 1 Barbiturate <input type="checkbox"/> 5 Not stated	
3. _____		_____		<input type="checkbox"/> 2 Cocaine <input type="checkbox"/> 6 Other: _____	
4. _____		_____		<input type="checkbox"/> 3 Cannabis _____	
5. _____		_____		_____	
<input type="checkbox"/> Newborn Screening		<input type="checkbox"/> Genetic Screening		<input type="checkbox"/> Genetic Counseling	
				<input type="checkbox"/> Physical Assessment	
Additional Data					
Height _____ ins.		Weight _____ lbs. _____ oz.		Head Circumference _____ cms.	
Hearing <input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Impaired <input type="checkbox"/> In Treatment				Denver II <input type="checkbox"/> Normal	
Vision <input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Impaired <input type="checkbox"/> Corrected With Surgery				<input type="checkbox"/> Suspect	
<input type="checkbox"/> Corrected With Lens <input type="checkbox"/> Legally Blind				<input type="checkbox"/> Untestable	
Support Service Referrals (check all that apply)					
<input type="checkbox"/> Audiology testing		<input type="checkbox"/> Genetic counseling/diagnosis		<input type="checkbox"/> Social services	

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<input type="checkbox"/> Department of Children and Family Services (DCFS)	<input type="checkbox"/> Home health	<input type="checkbox"/> Support group
<input type="checkbox"/> Developmental testing	<input type="checkbox"/> Nutritional services	<input type="checkbox"/> WIC/nutrition
<input type="checkbox"/> Division of Specialized Care for Children	<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Physical therapy	_____

Send original to Illinois Department of Human  
 Services, Office of Family Health, 535 W. Jefferson  
 St., Springfield, Illinois

\_\_\_\_\_  
 Signature of Nurse completing this form

Canary — Reporting Hospital  
 Pink — Local Health Agency  
 Goldenrod — Primary Care Physician

(Source: Repealed at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

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**Section 640.APPENDIX F Report of Local Health Nurse, Infant (Repealed)****Section 640.EXHIBIT B Instructions for Completing the Report of Local Health Nurse, Infant (Repealed)**~~INSTRUCTIONS FOR COMPLETION OF INFANT REPORT  
OF LOCAL HEALTH NURSE~~

~~Please Note: This form is only for statistical/tracking information for Illinois Department of Public Health (IDPH). The Cornerstone Physical Assessment—Child and Denver II will be the assessment tools.~~

<del>Infant's last name:</del>	<del>Last name of infant.</del>
<del>Infant's first name:</del>	<del>First name of infant.</del>
<del>Sex: male/female/unknown</del>	<del>Unknown indicates sexual ambiguity</del>
<del>Birth Date:</del>	<del>Infant's date of birth.</del>
<del>Cornerstone ID #:</del>	<del>Number assigned to infant by Cornerstone</del>
<del>Patient ID number:</del>	<del>The patient number given by the hospital to each infant which number is unique to each admission. Found on the Infant Discharge Record (IDR).</del>
<del>Infant Classification:</del>	
<del>APORS:</del>	<del>Check box if infant discharge record (APORS) received from hospital.</del>
<del>Genetics:</del>	<del>Check box if referred to genetics/for genetics services.</del>
<del>Both:</del>	<del>Check box if both APORS and Genetics.</del>
<del>Street address, apartment, city, zip code:</del>	<del>Address of infant: house number, street, apartment, city, zip code.</del>

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<del>Local health agency:</del>	<del>Name of health department or agency responsible for providing high risk follow-up.</del>
<del>Agency code:</del>	<del>IDPH code number of health department or agency responsible for providing high risk follow-up.</del>
<del>Hospital of delivery:</del>	<del>Hospital of infant's birth. Reporting hospital: Hospital providing the highest level of care and responsible for completing Infant Discharge Record.</del>
<del>Reporting hospital code:</del>	<del>IDPH code number of reporting hospital.</del>
<del>Chronological age:</del>	<del>Age of infant in weeks (during the first year of life) then in months, calculated from date of birth.</del>
<del>Corrected age:</del>	<del>Age of infant in weeks based on gestational age at birth (see (IDR). To determine corrected age at time of visit, subtract the gestational age from 40 weeks, then subtract this difference from the chronological age (weeks) at the time of the visit.</del>
<del>Mother, last name:</del>	<del>Last name of mother.</del>
<del>Mother, first name:</del>	<del>First name of mother.</del>
<del>Mother, maiden name:</del>	<del>Maiden name of mother.</del>
<del>Date of visit:</del>	<del>Date of visit to family by Local Health Nurse.</del>
<del>Visit number:</del>	<del>Number of times infant has been seen by Local Health Nurse.</del>
<del>Date case closed:</del>	<del>Enter date the Local Health Nurse closed the case for follow-up.</del>
<del>Case closed with visit: without visit:</del>	<del>Home visit made at closure. Closed without a home visit</del>

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<del>Reason for closure:</del>	<del>Circle appropriate reason case closed for all infants closed with and without visit.</del>
<del>Completed program:</del>	<del>Infant received 6 visits or more during the first 24 months of life.</del>
<del>Infant died:</del>	<del>Infant died after discharge from hospital.</del>
<del>Unable to locate:</del>	<del>Three unsuccessful attempts were made to locate infant. Attempts may include telephone contact; seeking the client in the home, clinic, school; and least preferable, by mail.</del>
<del>Refused visit:</del>	<del>Family refused home visit by nurse.</del>
<del>Services no longer needed:</del>	<del>Infant has minor anomaly (i.e., skin tag, anomaly of nails) that does not require follow-up.</del>
<del>Moved:</del>	<del>Family has moved out of area served by local health department. Refer to health department in other area.</del>
<del>Other:</del>	<del>Case closed for reason other those listed above. Specify reason.</del>
<del>Discharge diagnoses/additional:</del>	<del>Record up to 5 diagnoses: IDR diagnoses first, then additional diagnoses, if any.</del>
<del>ICD-9 Code:</del>	<del>For IDPH use only. IDPH will enter ICD-9 Code for each diagnosis.</del>
<del>Drug toxicity:</del>	<del>Check box if infant was diagnosed with drug toxicity.</del>
<del>Opioid:</del>	<del>If positive for drug toxicity, check all that have been identified.</del>
<del>Barbiturate:</del>	

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~~Cocaine:~~~~Cannabis:~~~~Mixed:~~~~Not stated:~~~~Other:~~~~Include drug if known.~~~~Newborn screening:~~~~Check box if newborn genetic/metabolic screening has been completed.~~~~Genetic screening:~~~~Check box if infant was screened later for any genetic assessed condition.~~~~Genetic counseling:~~~~Check box if family received information concerning genetics.~~~~Physical assessment:~~~~Check box if you (the nurse visiting the family) completed a physical assessment on this visit. The Cornerstone physical assessment is expected on each visit, and will be documented on your agency's records.~~~~Additional data:~~~~Height:~~~~Height measured in inches.~~~~Weight:~~~~Weight measured in pounds and ounces.~~~~Head circumference:~~~~Circumference of head measured in centimeters.~~~~Hearing:~~~~Based on gross evaluation during physical exam or as a result of formal testing.~~~~normal:~~~~Within normal limits.~~~~suspect:~~~~Possible visual impairment.~~~~impaired:~~~~Definite impairment.~~

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~~in treatment: Active treatment for hearing impairment; or corrected with treatment.~~

~~Vision: Based on gross evaluation during physical exam or as a result of formal testing.~~

~~normal: Within normal limits.~~

~~suspect: Possible visual impairment.~~

~~impaired: Definite impairment.~~

~~corrected with surgery:~~

~~corrected with lens:~~

~~legally blind: Determined by formal testing.~~

~~Denver II:~~

~~normal: No delays and a maximum of one caution.~~

~~suspect: Two or more cautions and one or more delays.~~

~~untestable: Refusal scores on one or more items completely to the left of the age line or on more than one item intersected by the age line on the 75% to 90% area. Prescreen in 1 to 2 weeks.~~

~~Support service referrals: Infant referred to one or more services. Check as many as apply.~~

~~Audiology testing  
Department of Children and Family  
Services (DCFS)~~

~~Developmental testing~~

~~Division of Specialized Care for Children~~

~~Early Intervention~~

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~~Genetic counseling/diagnosis~~

~~Home Health~~

~~Nutritional services~~

~~Occupational therapy~~

~~Physical therapy~~

~~Social services~~

~~Support group~~

~~WIC/nutrition~~

~~Other~~

~~Please specify.~~

~~Signature of Nurse completing this form.~~

~~Send original copy of form to:~~

~~Illinois Department of Public Health  
535 West Jefferson Street  
Springfield, IL 62761~~

~~Copies—Canary copy: reporting hospital~~

~~Pink copy: local health agency~~

~~Goldenrod copy: primary care physician~~

(Source: Repealed at 35 Ill. Reg. 2583, effective January 31, 2011)

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Section 640.APPENDIX G Sample Letter of Agreement

\_\_\_\_\_ (name ~~Name~~ of Administrative Perinatal Center) is recognized and designated by the Illinois Department of Public Health as a Level III Administrative Perinatal Center providing obstetrical and neonatal care. In order to serve as a Non-Birthing Hospital, Level I, II, II with Extended Neonatal Capabilities or III, affiliated with an Administrative Perinatal Center~~perinatal facility~~ designated by the Illinois Department of Public Health, \_\_\_\_\_ (name ~~Name~~ and address of hospital) agrees to affiliate with the above Administrative Perinatal Center.

This agreement is consistent with the ~~Adopted Rules of the~~ Illinois Department of Public Health, Regionalized Perinatal Health Care Code (77 Ill. Adm. Code 640).

Components for Letter of Agreement

- I. Introductory Remarks: The Administrative Perinatal Center may list items of organization of the Center.
- II. Administrative Perinatal Center Obligations
  - A. A 24-hour obstetrical and neonatal "hot-line" for immediate consultation, referral or transport of perinatal patients is available.

	Obstetrical		Neonatal
Hospital	Telephone #	Hospital	Telephone #

- B. The Administrative Perinatal Center ~~shall~~will accept all medically eligible obstetrical/neonatal patients.
- C. If the above named Administrative Perinatal Center is unable to accept a referred maternal or neonatal patient because of bed unavailability, that Center ~~shall~~will assist in arranging for admission of the patient to another hospital~~facility~~ capable of providing the appropriate level of care.
- D. Transportation of neonatal patients remains the responsibility of the Administrative Perinatal Center. Decisions regarding transport and mode of transport will be made by the Administrative Perinatal Center neonatologist in collaboration with the referring health care provider~~physician~~.

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- E. Transportation of the obstetrical patient remains the responsibility of the (Level I, Level II, Level II with Extended Neonatal Capabilities or Level III hospital facility). Decisions regarding transport, transfer and mode of transport or transfer shall will be made by the Administrative Perinatal Center maternal-fetal ~~Maternal-Fetal~~ medicine ~~Medicine~~ physician in collaboration with the referring health care provider ~~physician~~.
- F. The maternal-fetal medicine ~~Maternal-Fetal Medicine~~ physician of the Administrative Perinatal Center, in collaboration with the referring health care provider, shall physician will decide whether to have an obstetrical patient stabilized before transfer, kept in the affiliated unit or transferred immediately. The best possible alternatives and the staff needed for transport shall will be determined.
- G. The Administrative Perinatal Center shall distribute written ~~Written~~ protocols for the mechanism of referral/transfer/transport will be distributed by the Perinatal Center ~~to the affiliated hospital physician, administration and nursing service. Protocols are~~ This is to include a mechanism for data recording of the time, date and circumstances of transfer so that this information can be utilized as part of the morbidity and mortality reviews. (See Appendix A.)
- H. The Administrative Perinatal Center shall send a ~~A~~ written summary of patient management and outcome will be sent by the Perinatal Center to the referring health care provider ~~physician~~ of record and to the hospital ~~hospital's chart~~.
- I. The Administrative Perinatal Center shall will conduct quarterly ~~periodic~~ mortality and morbidity conferences at \_\_\_\_\_ Hospital.
1. The Administrative ~~conference will be conducted by the~~ Perinatal Center's Perinatal Network Administrator, maternal-fetal medicine ~~Maternal-Fetal Medicine~~ physician, neonatologist, nursing coordinator ~~and/or obstetrical and neonatal nurse educators~~ shall conduct the conference.
  2. \_\_\_\_\_ Hospital shall will prepare written summaries of cases and statistics for discussion, to be available to the Administrative Perinatal Center at least one week prior to the conference.
  3. The content of the review will be determined by the Regional Quality

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~~Council Perinatal Management Group~~ of each Regional Perinatal Network shall determine the content of the review. The review ~~shall~~ must include, but not be limited to, stillbirths, neonatal deaths, maternal and/or neonatal transports.

- J. The Administrative Perinatal Center ~~shall~~ will transfer patients back to the referring hospital when medically feasible, in accordance with physician to physician consultation.
- K. The Administrative Perinatal Center ~~shall~~ will develop and offer Perinatal Outreach Education programs~~Education program~~ at a reasonable cost to include the following:
1. On-site consultation by Administrative Perinatal Center physicians and nurse educators as needed.
  2. Periodic obstetrical and neonatal needs assessment of \_\_\_\_\_ Hospital.
  3. Provide \_\_\_\_\_ Hospital with protocols for patient management.
  4. Develop Continuing Medical Education programs for obstetricians, pediatricians and family practitioners either at \_\_\_\_\_ Hospital or at the Administrative Perinatal Center site.
  5. Mini-Fellowships at the Administrative Perinatal Center for \_\_\_\_\_ Hospital physicians and nurses.
  6. Programs based on needs assessment by outreach nurse educators at \_\_\_\_\_ Hospital for obstetrical and neonatal nursing staff.
- L. The Administrative Perinatal Center ~~shall~~ will establish, maintain and coordinate the educational programs offered ~~by and~~ for all Non-Birthing Centers, Level I, Level II, Level II with Extended Neonatal Capabilities, and Level III ~~hospitals~~Hospitals that it serves for which they serve.
- M. The Administrative Perinatal Center shall develop a Regional Quality Council, ~~Perinatal Management Group~~, including, but not limited to, representatives of each

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hospital in the [Regional](#) Perinatal Network. This group shall meet at least quarterly to plan management strategies, evaluate morbidity and mortality reviews, evaluate the effectiveness of current programs and services and ~~to~~ set future goals. The Regional [Quality Council](#)~~Perinatal Management Group~~ shall determine the data collection system to be used by the Regional Perinatal Network.

## III. \_\_\_\_\_ Hospital Obligations

- A. \_\_\_\_\_ Hospital ~~shall~~[will](#) utilize the "hot-line" established by the [Administrative](#) Perinatal Center for consultation, referral and transport.
- B. \_\_\_\_\_ Hospital ~~shall~~[will](#) transfer to \_\_\_\_\_ [Administrative](#) Perinatal Center obstetrical and neonatal patients who require the services of the [Administrative](#) Perinatal Center, including, but not limited to, patients outlined in the [Regionalized Perinatal Health Care Code](#)~~perinatal rules and regulations (See Appendix H, Exhibits A and B) for patients to be included for consultation, treatment or transfer~~.
- C. \_\_\_\_\_ Hospital (level of care) ~~shall~~[will](#) usually care for the following maternal and neonatal patients. ~~(See Appendix H, Exhibits B and C)~~
- D. \_\_\_\_\_ Hospital ~~shall~~[will](#) develop an ongoing in-house continuing educational program for the obstetrical and neonatal medical staff and other disciplines as needed.
- E. \_\_\_\_\_ Hospital ~~shall~~[will](#) participate in continuing educational programs for both nurses and physicians developed by the \_\_\_\_\_ [Administrative](#) Perinatal Center. Cost to be shared.
- F. \_\_\_\_\_ Hospital ~~shall~~[will](#) designate representatives to serve on the \_\_\_\_\_ Regional [Quality Council](#)~~Perinatal Management Group~~.
- G. \_\_\_\_\_ Hospital ~~shall~~[will](#) establish a Perinatal Development Committee composed of medical and nursing representatives from both neonatal and obstetrical areas, administration and any other individuals deemed appropriate.
- H. \_\_\_\_\_ Hospital ~~shall~~[will](#) maintain and share such statistics as the \_\_\_\_\_ Regional [Quality Council](#)~~Perinatal Management Group~~

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may deem appropriate.

- I. \_\_\_\_\_ Hospital ~~shall~~ develop or to utilize programs at \_\_\_\_\_ Administrative Perinatal Center for follow-up of neonates with handicapping conditions.

IV. Joint Responsibilities

- A. This agreement will be valid for ~~three years~~one year, at which time it may be renewed or re-negotiated.
- B. If either \_\_\_\_\_ Hospital or the \_\_\_\_\_ Administrative Perinatal Center ~~wishes~~wish to change an individualized portion of this agreement, either may initiate the discussion. If a change in the agreement is reached, ~~the change~~it must be reviewed by the Department Perinatal Advisory Committee. If the \_\_\_\_\_ Hospital wishes to make a change and \_\_\_\_\_ Administrative Perinatal Center is not in agreement, \_\_\_\_\_ Hospital can request a hearing by the Department Perinatal Advisory Committee.
- C. If any of the institutions wants to terminate the agreement, written notification ~~shall~~must be given to the Department and other participating institutions six months in advance.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX H Written Protocol for Consultation~~Referral~~/Transfer/Transport****Section 640.EXHIBIT A Level I: Patients for consultation with \_\_\_\_\_ (Level III hospital~~facility~~ or Administrative Perinatal Center)**

## 1) Maternal Conditions

## A) Previous Pregnancy Problems:

- i) Premature infant
- ii) Perinatal death or mental retardation
- iii) Isoimmunization
- iv) Difficult deliveries
- v) Congenital malformations
- vi) Mid-trimester loss

## B) Current Pregnancy Problems:

- i) Any medical disorder (e.g., diabetes mellitus, hemoglobinopathy, chronic hypertension, heart disease, renal disease)
- ii) Drug addiction
- iii) Multiple gestation
- iv) Intrauterine growth retardation
- v) Preterm labor less than or equal to 36 weeks
- vi) Postdate greater than or equal to 42 weeks
- vii) Third trimester bleeding
- viii) Abnormal genetic evaluation

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ix) Pregnancy induced hypertension

2) Neonatal Conditions

- A) Gestation less than or equal to 36 weeks, weight less than or equal to 2500 grams
- B) Small-for-gestational age (less than 10<sup>th</sup> percentile)
- C) Sepsis
- D) Seizures
- E) Congenital heart disease
- F) Multiple congenital anomalies
- G) Apnea
- H) Respiratory distress
- I) Neonatal asphyxia
- J) HandicappingInfants identified as having handicapping conditions or developmental disabilities that~~which~~ threaten life or subsequent development
- K) Severe anemia
- L) Hyperbilirubinemia, not due to physiologic cause
- M) Polycythemia

3) Consultation and transfer to a Level III or Administrative Perinatal Center shall occur for the following conditions:

- A) Premature labor or premature birth less than 34 weeks gestation.
- B) Birth weight~~Birthweight~~ less than or equal to 2000 grams.

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4) Exceptions:

- A) ~~Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes, and geography in the regional perinatal network.~~
- B) ~~Exceptions to the standards of care of this Part may be granted when the facility requesting an exception demonstrates that the staffing, equipment and quality of care (outcomes), are substantially equivalent to the standards and quality of care for any Level II or Level III facility in their Regional Perinatal Network.~~
- C) ~~Such exceptions shall be negotiated between the applicant facility and their Perinatal Center. The applicant facility or the Perinatal Center shall seek the advice and consultation of the Department, as well as the Perinatal Advisory Committee, to facilitate negotiations regarding exceptions to these standards of care. Any exception to the standards of care of this Part must be defined in the letter of agreement.~~
- D) ~~The Department shall review all letters of agreement and modification of letters of agreement. The Department shall use the criteria described in Section 640.41(e)(2) in order to approve or deny approval of any provision of or any letter of agreement.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX H Written Protocol for ConsultationReferral/Transfer/Transport**

**Section 640.EXHIBIT B Level II: Patients for consultation with or transfer to  
\_\_\_\_\_ (Level III hospitalfacility or Administrative Perinatal Center)**

- 1) Maternal Conditions (Consultation)
  - A) Essential hypertension on medication.
  - B) Chronic Renal disease.
  - C) Chronic medical problems with known increase in perinatal mortality or morbidity.
  - D) Prior birth of neonate with serious complication resulting in a handicapping condition.
  - E) Abnormalities of the reproductive tract known to be associated with an increase in preterm delivery.
  - F) Previous delivery of preterm infant 34 weeks gestation.
  - G) Insulin-dependent diabetes Class B or greater.
- 2) Maternal Conditions (Transfer)
  - A) Patients from the above consultation list, for whom transfer is~~which~~ deemed advisable by mutual collaboration between the maternal-fetal medicine~~Maternal-Fetal Medicine~~ physician at the Level III hospitalfacility and the obstetrician at the referring office of the hospital.
  - B) Isoimmunization with possible need for intrauterine transfusion.
  - C) Suspected congenital anomaly compatible with life.
  - D) Insulin-dependent diabetes mellitus.
  - E) Cardiopulmonary disease with functional impairment.

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- F) Multiple gestation, with exception of twins.
  - G) Premature labor prior to 32 weeks.
  - H) Premature rupture of membranes prior to 32 weeks.
  - I) Medical and obstetrical complication of pregnancy, possibly requiring induction of labor or cesarean section for maternal or fetal conditions prior to 32 weeks gestation.
  - J) Severe pre-eclampsia or eclampsia.
- 3) Neonatal Conditions (Consultation or transfer): Specify whether consultation or transfer will ~~occur~~ be done for each of the following:
- A) Gestation less than 32 weeks or less than 1800 grams.
  - B) Sepsis unresponsive to therapy.
  - C) Uncontrolled seizures.
  - D) Significant congenital heart disease.
  - E) Major ~~congenital~~ congenital malformations requiring surgery.
  - F) ~~Assisted ventilation required~~ ~~Infants requiring ventilation~~ after initial stabilization (greater than 6 hours).
  - G) ~~Oxygen~~ ~~Infants with oxygen~~ requirements in excess of 50% (greater than 6 hours).
  - H) ~~10-Infants with ten~~ minute Apgar scores of 5 or less.
  - I) ~~Major~~ ~~All neonates requiring major~~ surgery.
  - J) ~~Exchange~~ ~~Infants requiring exchange~~ transfusion.
  - K) Persistent metabolic derangement (e.g., hypocalcemia, hypoglycemia, metabolic acidosis).

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- L) ~~Handicapping~~ ~~Infants identified as having handicapping~~ conditions or developmental disabilities ~~that~~ ~~which~~ threaten life or subsequent development.
- 4) Consultation and transfer to a Level III hospital or Administrative Perinatal Center shall occur for the following conditions:
- A) Premature labor or premature birth less than 34 weeks gestation.
- B) Birth weight ~~Birthweight~~ less than or equal to 2000 grams.
- C) Assisted ~~Mechanical~~ ventilation beyond the initial stabilization period (6 hours).
- 5) Exceptions:
- A) ~~Exceptions to the standards of care set forth in this Part may be necessary based on patient care needs, current practice, outcomes, and geography in the regional perinatal network.~~
- B) ~~Exceptions to the standards of care of this part may be granted when the facility requesting an exception demonstrates that the staffing, equipment and quality of care (outcomes), are substantially equivalent to the standards and quality of care for any Level II or Level III facility in their Regional Perinatal Network.~~
- C) ~~Such exceptions shall be negotiated between the applicant facility and their Perinatal Center. The applicant facility or the Perinatal Center may seek the advice and consultation of the Department, as well as the Perinatal Advisory Committee, to facilitate negotiations regarding exceptions to these standards of care. Any exception to the standards of care of this part must be defined in the letter of agreement.~~
- D) ~~The Department shall review all letters of agreement and modification of letters of agreement. The Department shall use the criteria described in Section 640.41(e)(2) in order to approve or deny approval of any provision of or any letter of agreement.~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX H** Written Protocol for ~~Consultation~~Referral/Transfer/Transport

**Section 640.EXHIBIT C** Level I: Maternal and ~~neonatal~~Neonatal patients to be cared for at \_\_\_\_\_ hospital (Level III ~~hospital~~facility or Administrative Perinatal Center)

1) Maternal

The maternal patient with an uncomplicated current pregnancy.

2) Neonatal

The neonatal patient greater than 34 weeks gestation or greater than 2000 grams without risk factors and infants with physiologic jaundice.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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Section 640.APPENDIX H Written Protocol for ConsultationReferral/Transfer/Transport

Section 640.EXHIBIT D Level II: Maternal and neonatal patients to be cared for at  
\_\_\_\_\_ hospital (Level III hospitalfacility or Administrative Perinatal Center)

## 1) Maternal

- A) The maternal patient with uncomplicated current pregnancy.
- B) Patient with normalNormal current pregnancy, although previous history may suggestbe suggestive of potential difficulties.
- C) Patient with selectedSelected medical conditions, such as mild hypertension or controlled thyroid disease, whenwhere there is no increase in perinatal morbidity.
- D) Patient with selectedSelected obstetric complications such as pre-eclampsia or premature labor greater than 34 weeks.
- E) Patient with an incompetent cervixIncompetent.
- F) Patient with gestational diabetesGestational.

## 2) Neonatal

- A) PatientsNeonatal patients greater than 34 weeks gestation or greater than 1800 grams without risk factors.
- B) Patients with mildMild to moderate respiratory distress (not requiring assistedmechanical ventilation in excess of 6 hours).
- C) Patients with suspectedSuspected neonatal sepsis, hypoglycemia, neonates of diabetic mothers and post-asphyxia without life-threatening sequelae.
- D) PrematureNursing care of premature infants greater than 1800 grams who are otherwiseother wise well.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX I Perinatal Reporting System Data Elements**

1. Child's First Name
2. Child's Middle Name
3. Child's Last Name
4. Child's Suffix
5. AKA
6. Child's Date of Birth
7. Child's Time of Birth
8. Sex
  - A. Male
  - B. Female
  - C. Ambiguous
9. Child of Hispanic Origin~~Race~~
  - A. Yes
    - Cuban
    - Mexican
    - Puerto Rican
  - B. No
    - ~~A. White~~
    - ~~B. Black~~
    - ~~C. Asian~~
    - ~~D. Other~~

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10. Race ~~Hispanic~~

A. Asian

B. Black

C. Caucasian

D. Native American

E. Other

~~A.~~ Yes

~~B.~~ No

~~C.~~ N/A

11. Place of Birth

12. City of Birth

13. County of Birth

14. Mother's First Name

15. Mother's Middle Name

16. Mother's Last Name

17. Mother's Maiden Name

18. Mother's Social Security Number

19. Mother's Date of Birth

20. Mother's Street Number

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- 21. Mother's Street Name
- 22. Mother's Street Direction
- 23. Mother's Street Type
- 24. Mother's Street Location
- 25. Mother's City
- 26. Mother's County
- 27. Mother's Zip Code
- 28. Mother's State
- 29. Mother's Telephone
- 30. Mother's Age
- 31. Mother's Birthplace
  - A. \_\_\_\_\_ State
  - B. \_\_\_\_\_ County
- 32. Mother of Hispanic Origin
  - A. Yes
    - Cuban
    - Mexican
    - Puerto ~~Rican~~Riceo
  - B. No
- 33. Mother's Race
  - A. Asian

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B. Black

C. Caucasian

D. Native American

E. Other

~~A. American Indian~~

~~B. Black~~

~~C. White~~

34. Mother's Education (specify highest grade completed~~completion~~)

35. Mother's Occupation

36. Mother's Business/Industry

37. Mother Employed During Pregnancy

A. Yes

B. No

C. Record Not Available (N/A)

D. Not Stated

38. Marital~~Martial~~ Status

A. Married

B. Not Married

39. Father's Last Name



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48. Father Employed
- A. Yes
  - B. No
  - C. Record N/A
  - D. Not Stated
49. Pregnancy History
50. Plurality (# this Birth)  
If greater than 1, Birth Order of this Birth
51. Previous Live Births
52. Number Live Births Now Living
53. Number Live Births Now Dead
54. Date of Last Live Birth
55. Previous Terminations
56. Number of Other Terminations
57. Date of Last Other Termination
- | 58. Date of Last Normal Menses
59. Month Prenatal Care Began
60. Number of Prenatal Care Visits
- | 61. 1 Minute Apgar ~~APGAR~~ Score

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62. 5 Minute ~~Apgar~~APGAR Score
63. Estimate of Number of Gestation Weeks
64. Mother Transferred In Prior to Delivery
- A. Yes
- B. Name of HospitalFacility \_\_\_\_\_  
Location of HospitalFacility \_\_\_\_\_
- C. No
65. Infant Transferred (Out)
- A. Yes
- B. Name~~Names~~ of HospitalFacility \_\_\_\_\_  
Location of HospitalFacility \_\_\_\_\_
- C. Transfer Code
- D. No
66. Reporting Hospital
67. Reporting Hospital City
68. Tobacco Use During Pregnancy
- A. Smoked during pregnancy  
Average cigarettes per day \_\_\_\_\_
- B. Stopped smoking during pregnancy
- ~~C. Smoked during pregnancy~~
- C.D. Does not smoke

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| ~~D.E.~~ Record N/A

| ~~E.F.~~ Not Stated

## 69. Alcohol Use During Pregnancy

- A. Yes  
Average number drinks per day \_\_\_\_\_
- B. No
- C. Record N/A
- D. Not Stated

## 70. Mother's Weight Gain

- A. Yes  
Pounds \_\_\_\_\_
- B. No
- C. Record N/A
- D. Not Stated

## 71. Mother's Weight Loss

- A. Yes  
Pounds \_\_\_\_\_
- B. No
- C. Record N/A
- D. Not Stated

## 72. Medical Risk Factors for this Pregnancy

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- A. Anemia
  - B. Cardiac Disease
  - C. Acute or Chronic Lung Disease
  - D. Diabetes
  - E. Genital Herpes
  - F. Hydramnios/[Oligohydramnios](#)~~Oligohydramines~~
  - G. Hemoglobinopathy
  - H. Hypertension, Chronic
  - I. Hypertension, [Pregnancy-related](#)~~Pregnancy-related~~
  - J. Eclampsia
  - K. Incompetent Cervix
  - L. Previous Infant 4000 + Grams
  - M. Previous Preterm or [Small-for-Gestational-Age \(SGA\)](#)~~SGA~~ Infant
  - N. Renal Disease
  - O. Rh Sensitization
  - P. Uterine Bleeding
  - Q. None
  - R. Other, Specify
73. Obstetric Procedures

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A. ~~Amniocenteses~~ Aminocentesis

B. Electronic Fetal Monitoring  
 Internal  
 External  
 Both  
 Neither  
 Record N/A  
 Not Stated

C. Induction of Labor

D. Stimulation of Labor

~~K.~~ Yes  
 Pitocin \_\_\_\_\_  
 Oxytocin \_\_\_\_\_

~~L.~~ No

~~M.~~ Record N/A

~~N.~~ Not Stated

~~E.Q.~~ Tocolysis

~~F.P.~~ Ultrasound

~~G.Q.~~ None

~~H.R.~~ Other, Specify

## 74. Complications of Labor and/or Delivery

A. Febrile

B. Meconium

C. Premature Rupture

D. Abruptio Placenta

E. Placenta Previa

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- F. Other Excessive ~~Bleeding~~bleeding
- G. Seizures ~~During Labor~~during labor
- H. Precipitous ~~Labor~~labor
- I. Prolonged ~~Labor~~labor
- J. Dysfunctional ~~Labor~~labor
- K. Breech/Malpresentation
- L. Cephalopelvic Disportion
- M. Cord Prolapse
- N. Anesthetic ~~Complication~~complications
- O. Fetal Distress
- P. None
- Q. Other, Specify

## 75. Method of Delivery

- A. ~~Spontaneous~~Spontaneous Vaginal
- B. Mid – Low Forceps
- C. Vacuum Extraction
- D. Vaginal Breech
- E. ~~Caesarean~~Caesarean Section Primary
- F. ~~Caesarean~~Caesarean Section Repeat

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- | G. Other Typetype
  - H. Record N/A
  - I. Not Stated
  - | J. Vaginal Birth After Previous Caesarean Section (VBAC)
  - | K. Other Caesarean Section
- 76. Abnormal Conditions of Newborn
  - 77. Anemia
  - 78. Birth Injury
  - 79. Fetal Alcohol Syndrome
  - 80. Hyaline Membrane Disease
  - 81. Meconium Aspiration Syndrome
  - 82. Assisted Ventilation > 30 min.
  - 83. Assisted Ventilation = 30 min.
  - 84. Seizures
  - | 85. Human Immunodeficiency Virus (HIV)~~None~~
  - | 86. Other, Specify
  - | 87. Congenital Anomalies of Newborn~~Child~~
  - | 88. Anencephalous~~Anacephalus~~
  - | 89. Congenital Syphilis
  - | 90. Hypothyroidism

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91. [Adrenogenital Syndrome](#)

92. [Inborn Errors of Metabolism](#)

93. [Cystic Fibrosis](#)

94. [Immune Deficiency Disorder](#)

95. [Retinopathy of Prematurity](#)

96. [Chorioretinitis](#)

97. [Strabismus](#)

98. [Intrauterine Growth Restriction](#)

99. [Cerebral Lipidoses](#)

~~100.89.~~ Spina Bifida/Meningocele

~~101.90.~~ Hydrocephalus

~~102.91.~~ Microcephalus

~~103.92.~~ Other CNS Anomalies, Specify \_\_\_\_\_

~~104.93.~~ Heart Malformations, Specify \_\_\_\_\_

~~105.94.~~ Other Circulatory/Respiratory Anomalies, Specify \_\_\_\_\_

~~106.95.~~ Rectal Atresia/Stenosis

~~107.96.~~ Tracheoesophageal Fistula/Esophageal Atresia

~~108.97.~~ Omphalocele/Gastrochisis

~~109.98.~~ Other Gastrointestinal Anomaly

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- | ~~110.99.~~ Malformed Genitalia
- | ~~111.100.~~ Renal Agenesis
- | ~~112.101.~~ Other Urogenital Anomaly, Specify \_\_\_\_\_
- | ~~113.102.~~ Cleft Lip/Palate, Specify \_\_\_\_\_
- | ~~114.103.~~ Polydactyly/Syndactyly/~~Adactyly~~~~Adetyly~~
- | ~~115.104.~~ Club Foot
- | ~~116.105.~~ Diaphragmatic Hernia
- | ~~117.106.~~ Other ~~Musculoskeletal~~~~Musuloskeletal~~/Integumental Anomaly
- | ~~118.107.~~ ~~Down's~~~~Downs~~ Syndrome
- | ~~119.108.~~ Other Chromosomal Anomaly, Specify \_\_\_\_\_ Specify
- | ~~120.109.~~ None
- | ~~121.110.~~ Other, Specify \_\_\_\_\_
- | ~~122.111.~~ Transfusion
- | ~~123.112.~~ Anesthesia
  - A. Local/Pudenal
  - B. Regional
  - C. General
- | ~~124.113.~~ Umbilical Cord Blood Gases Tested
  - A. Yes
  - B. No

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- | ~~125.114.~~ Small-for-Gestational-Age ([SGA](#))
- | ~~126.115.~~ Infection of Newborn Acquired Before Birth
- | ~~127.116.~~ Infection of Newborn Acquired During Birth
- | ~~128.117.~~ Infection of Newborn Acquired After Birth
- | ~~129.118.~~ Hereditary Hemolytic Anemias
- | ~~130.119.~~ Hemolytic Diseases of the Newborn
- | ~~131.120.~~ Due to Rh Incompatibility Only
- | ~~132.121.~~ Due to ABO Incompatibility
- | ~~133.122.~~ Due to Other Causes
- | ~~134.123.~~ Drug Toxicity or Withdrawal
  - A. Yes, Specify \_\_\_\_\_
  - B. No
- | ~~135.124.~~ Highest Bilirubin, [Total](#) \_\_\_\_\_
- | ~~136.125.~~ Admit to Designated Patient Unit
  - A. Yes
  - B. No
- | ~~137.126.~~ Genetic Screenings Conducted
- | ~~138.127.~~ Rh Determination
  - A. Mother's Blood Type \_\_\_\_\_ Rh Factor \_\_\_\_\_  
Immune Globulin Given

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- | [B.](#) Yes
- | [C.](#) No
- | [139.128.](#) Hepatitis B – Surface Antigen
  - A. Positive
  - B. Negative
- | [140.129.](#) Non-Obstetrical Infections
  - A. Syphilis
  - B. Gonorrhea
  - C. Rubella
  - D. Other
- | [141.130.](#) Obstetrical Infections
  - A. Antepartum  
Amnionitis/Chioramnionitis  
Urinary Tract Infection
  - B. Postpartum  
Endometritis  
Infection of Wound  
Urinary Tract Infection
- | [142.131.](#) Mother admitted ~~within~~with 72 hours ~~after~~of delivery
  - A. Precipitous Delivery
  - B. Planned Home Birth
- | [143.132.](#) Drug Use During Pregnancy

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A. Cocaine

B. Heroin

C. Marijuana

D. Other Street ~~Drugs~~ Drug(s)

E. None

F. Record N/A

G. Not Stated

~~144.133.~~ Transfusion

~~145.134.~~ Prenatal Screening Conducted for

A. Gestational Diabetes  
(Blood Glucose Tolerance Test)

B. Congenital/Birth Defects

A. Maternal Alpha Feta Protein

B. Chromosomal

C. Other

~~146.135.~~ Number of Days Maintained on Ventilation Before Transfer to Level III Center-Days

~~147.136.~~ Prenatal Ultrasound

A. Yes

B. No

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C. Record N/A

D. Not Stated

| ~~148.137.~~ Chorionic Villus Sampling

| ~~149.138.~~ Were Newborn Screening Tests Conducted?

A. Yes

B. No

| ~~150.139.~~ Mother Transferred Out to Another Hospital After Delivery Destination Hospital Code

| ~~151.140.~~ Mother Transferred From Emergency Room

| ~~152.141.~~ Infant Transferred In Transfer Code

| ~~153.142.~~ Consult [Administrative](#) Perinatal Center [or Another Level III](#)

| ~~154.143.~~ Infant                      Maternal

A.                      A.                      Yes, [with](#) ~~W~~/Transfer

B.                      B.                      Yes, No Transfer

C.                      C.                      No Consultation

D.                      D.                      Not Stated

| ~~155.144.~~ Mother Died In Hospital

| ~~156.145.~~ Fetal Death

| ~~157.146.~~ Infant Died in Hospital

| ~~158.147.~~ Extrauterine Pregnancy

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- | ~~159.148.~~ Ectopic Pregnancy
- | ~~160.149.~~ Admission Date – Infant
- | ~~161.150.~~ Admission Date – Maternal
- | ~~162.151.~~ Discharge Date – Infant
- | ~~163.152.~~ Discharge Date – Maternal
- | ~~164.153.~~ Payment Method
- A. Yes
- Medicaid  
Medicaid HMO  
HMO  
Medicare  
CHAMPUS  
Title V  
Health ~~Insurance~~  
Self Pay  
~~Record N/A~~  
Not Stated  
~~Health Ins/\$/~~  
Other, Specify \_\_\_\_\_
- B. No
- | ~~165.154.~~ Were prenatal records available prior to delivery?
- A. Yes
- B. No
- | ~~166.155.~~ Maternal Diagnosis (Specify up to 8 Diagnoses)
- | ~~167.156.~~ Mother's Medical Record Number \_\_\_\_\_

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~~168.157.~~ Infant Diagnoses (Including Congenital Anomalies); Specify up to 8 ~~Diagnoses~~diagnosis

~~169.158.~~ Infant Released to:

A. Home

B. Other Hospital Name and Location \_\_\_\_\_

C. Long Term Care Name and Location \_\_\_\_\_

D. Other Child Care Agency Name and Location \_\_\_\_\_

~~170.159.~~ Infant Patient ID

~~171.160.~~ Infant Medical Record Number \_\_\_\_\_

~~172.161.~~ Referrals

A. Community Social Services

B. [Division of Specialized Services for Children \(DSCC\)](#)

~~C.~~ [DCFS](#)

~~C.~~ [Department of Healthcare and Family Services \(HFS\)](#)

~~D.~~ [Department of Children and Family Services \(DCFS\)](#)

~~E.D.~~ Other, Specify \_\_\_\_\_

~~F.E.~~ None

~~G.F.~~ Early Intervention program

~~H.G.~~ Other \_\_\_\_\_

~~173.162.~~ Feedings

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<del>174.163.</del>	Breast <del>Fed</del> fed
<del>175.164.</del>	Bottle
<del>176.165.</del>	Tube
<del>177.166.</del>	Formula
<del>178.167.</del>	Frequency
<del>179.168.</del>	Amount
<del>180.169.</del>	Infant Medications
<del>181.170.</del>	Birth Weight
<del>182.171.</del>	Birth Head Circumference
<del>183.172.</del>	Birth Length
<del>184.173.</del>	Discharge Weight
<del>185.174.</del>	Discharge Head Circumference
<del>186.175.</del>	Discharge Length
<del>187.176.</del>	Infant Discharge Treatment
<del>188.177.</del>	Other Concerns
<del>189.178.</del>	RN Contact at Hospital – Phone Number
<del>190.179.</del>	Relative/Friend
<del>191.180.</del>	Relationship
<del>192.181.</del>	Address/Phone #

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| ~~193.182.~~ Family ~~Informed~~~~informed~~ of ~~Local Health Nurse~~~~LHN~~ Visit

A. Yes

B. No

| ~~194.183.~~ Primary Care Physician's Name –

| ~~195.184.~~ Mother Gravida Para F\_ P\_ A\_ L\_

| ~~196.185.~~ Signature

| ~~197.186.~~ Title

| ~~198.187.~~ Report Date

~~188. Other Infant Diagnoses~~

~~189. Congenital Syphilis~~

~~190. Hypothyroidism~~

~~191. Adrenogenital Syndrome~~

~~192. Inborn Errors of Metabolism~~

~~193. Cystic Fibrosis~~

~~194. Immune Deficiency Disorder~~

~~195. Leukemia~~

~~196. Constitutional Aplastic Anemia~~

~~197. Coagulation Defects~~

~~198. Neurofibromatosis~~

~~199. Retinopathy of prematurity~~

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- 200. ~~Chorioretinitis~~
- 201. ~~Strabismus~~
- 202. ~~Endocardial Fibroelastosis~~
- 203. ~~Occlusion of Cerebral Arteries~~
- 204. ~~Intrauterine Growth Retardation~~
- 205. ~~Cerebral Lipidoses~~

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX J Guideline for Application Process for Designation, Redesignation or Change in Designation****Initial Process:**

The hospital administration shall:

Send a Letter of Intent for change in status to the Department and affiliated Administrative Perinatal Center 6 to 12 months before expected review by the PAC.

Prepare appropriate documents for site visit. Required documents and assistance with preparation are available through affiliate Administrative Perinatal Center. The site visit team will include, but not be limited to, Co-Directors of Administrative Perinatal Center and Network Administrator, Perinatal Advisory Committee and Department. The Department will assign the additional representatives required.

Send information three weeks in advance of the scheduled site visit to:

Illinois Department of Public Health  
Perinatal Program Administrator  
535 West Jefferson  
Springfield, Illinois 62761

Assemble appropriate representation from the hospital on the day of the site visit to be available to present an overview of the hospital and to answer questions from the site visit team. Hospital representatives should include at a minimum:

- Hospital administration
- Chair of OB/GYN
- Chair of Family Practice, if appropriate
- Chair of Pediatrics
- Director of Anesthesiology
- Director of Maternal-Fetal Medicine, if appropriate
- Director of Neonatology, if appropriate
- Director of Nursing

Once the site visit has been completed and the hospital and Administrative Perinatal Center are satisfied that the application is complete, the Administrative Perinatal Center will contact the Department in writing to schedule application review before the Perinatal Advisory Committee.

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On the day of the review, the following representatives must be present from the hospital to be reviewed:

- Hospital administration
- Chair of OB/GYN
- Chair of Family Practice, if appropriate
- Chair of Pediatrics
- Director of Maternal-Fetal Medicine, if appropriate
- Director of Neonatology, if appropriate
- Director of Nursing
- Co-Directors of Affiliate Perinatal Network
- Network Administrator from Affiliate Perinatal Network
- Other personnel as identified by hospital, Perinatal Advisory Committee or Sub-Committee

After reviewing the application, the PAC will present a formal outline of the issues and recommendations to the Department.

After review of the recommendations and deliberations, the Department will send a formal letter as to the status of the hospital.

The hospital and the Administrative Perinatal Center will work together to address the recommendation in the follow-up letter.

The Administrative Perinatal Center will be responsible for monitoring any indicators or required changes that are identified by the PAC.

In preparation for re-review, the hospital and Administrative Perinatal Center will prepare information only on issues addressed in the follow-up letter.

The Administrative Perinatal Center will contact the Department to schedule the re-review meeting.

The Administrative Perinatal Center will send appropriate documents, identified in the follow-up letter, to the Department three weeks before the re-review is scheduled.

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Only representatives from the Administrative Perinatal Center shall attend the re-review meeting to answer any questions the review committee may have concerning the identified items. Hospital representatives may attend the meeting if they choose.

The Illinois Department of Public Health will send a formal follow-up letter to the hospital and the Administrative Perinatal Center concerning the outcome of the meeting and any follow-up instructions.

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX K Elements for Submission for Designation, Redesignation or Change in Designation****Level III Review**

- [Appendix A](#)
- [Resource Checklist for Level III](#)
- [Evaluation letter from Administrative Perinatal Center](#)
- [Vita for co-directors](#)
- [Credentials for Obstetric \(OB\)/Family Practice \(FP\) physicians, Advance Practice Nurses \(APN\), Neonatology & Anesthesia](#)
- [Copy of OB/Peds Departmental Rules](#)
- [Maternal-Fetal Medicine \(MFM\), Neonatology Consultation/referral tool/QA reports for 3 months](#)
- [Mortality and Morbidity \(M&M\) statistics and description of the process/participation](#)
- [Transport statistics, both into and out of hospital](#)
- [Listing of educational classes](#)
- [Description of educational classes](#)
- [Description of CQI](#)
- [3 months of call schedules for OB, Maternal-Fetal Medicine and Neonatology \(current and last 2 actual or 3 proposed schedules\)](#)

**Level II with Extended Neonatal Capabilities Review**

- [Appendix A](#)
- [Resource Checklist for Level II with Extended Neonatal Capabilities](#)
- [Evaluation letter from Administrative Perinatal Center](#)
- [Vita for Director of Neonatology, Maternal-Fetal Medicine \(MFM\), if appropriate](#)
- [Credentials for Obstetricians/Family Practice physicians, Advanced Practice Nurses \(APN\), Neonatology & Anesthesia](#)
- [Copy of OB/Peds Departmental Rules](#)
- [Consultation/referral tool/QA reports for 3 months](#)
- [Mortality and Morbidity \(M&M\) statistics and description of process/participation](#)
- [Transport statistics, both into and out of hospital](#)
- [Listing of educational classes](#)
- [Description of CQI](#)
- [3 months of call schedules for OB, MFM and Neonatology as appropriate](#)

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**Level II Review**

- [Appendix A](#)
- [Resource Checklist for Level II](#)
- [Evaluation letter from Administrative Perinatal Center](#)
- [Credentials for Obstetrics \(OB\)/Family Practice \(FP\) physicians, Advance Practice Nurses \(APN\), Neonatology & Anesthesia](#)
- [Copy of OB/Peds Departmental Rules](#)
- [Consultation/referral tool/QA reports for 3 months](#)
- [Mortality and Morbidity \(M&M\) statistics and description of process/participation](#)
- [Transport statistics – out of hospital](#)
- [Listing of educational classes](#)
- [Description of CQI](#)

**Level I Review**

- [Appendix A](#)
- [Resource Checklist for Level I](#)
- [Evaluation letter from Administrative Perinatal Center](#)
- [Credentials for Obstetrics \(OB\)/Family Practice \(FP\) physicians, Advance Practice Nurses \(APNs\), Neonatology & Anesthesia](#)
- [Mortality and Morbidity \(M&M\) statistics and description of process/participation](#)
- [Transport statistics – out of hospital](#)
- [Listing of educational classes](#)
- [Description of CQI](#)

**Administrative Perinatal Center**

- [Network description](#)
- [Educational programs](#)
- [Network projects](#)
- [Discussion with representatives from Regional Network Hospitals](#)
- [Network participation](#)
- [Network evaluation](#)
- [Network challenges](#)
- [Network M&M statistics](#)
- [University integration](#)

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX L Level I Resource Checklist****Level I Resource Checklist**  
**Briefly describe institutional compliance:**

1. The hospital shall provide continuing education for medical, nursing, respiratory therapy and other staff who provide general perinatal services, with evidence of a yearly competence assessment appropriate to the population served.

RECOMMENDATIONS:

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2. The hospital shall provide documentation of participation in Continuous Quality Improvement (CQI) implemented by the Administrative Perinatal Center.

RECOMMENDATIONS:

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3. The hospital shall provide documentation of the health care provider's risk assessment and consultation with a maternal-fetal medicine sub-specialist or neonatologist as specified in the letter of agreement and hospital's policies and procedures, and transfer to the appropriate level of care.

RECOMMENDATIONS:

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4. The hospital shall provide documentation of the availability of trained personnel and facilities to provide competent emergency obstetric and newborn care.

RECOMMENDATIONS:

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5. The hospital shall maintain a system of recording admissions, discharges, birth weight, outcome, complications and transports to meet the requirement to support CQI activities described in the hospital's letter of agreement with the Administrative Perinatal Center. The hospital shall comply with the reporting requirements of the State Perinatal Reporting System.

RECOMMENDATIONS:

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6. The hospital shall provide documentation of the capability for continuous electronic maternal-fetal monitoring for patients identified at risk with staff available 24 hours a day, including physicians and nursing, who are knowledgeable of electronic fetal

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monitoring use and interpretation. Staff shall complete a competence assessment in electronic maternal-fetal monitoring every two years.

RECOMMENDATIONS:

7. The hospital shall have the capability of performing caesarean sections (C-sections) within 30 minutes of decision-to-incision.

RECOMMENDATIONS:

8. The hospital shall have blood bank technicians on call and available within 30 minutes for performance of routine blood banking procedures.

RECOMMENDATIONS:

9. The hospital shall have general anesthesia services on call and available under 30 minutes to initiate C-section.

RECOMMENDATIONS:

10. The hospital shall have radiology services available within 30 minutes.

RECOMMENDATIONS:

11. The hospital shall have the following clinical laboratory resources available:

Microtechniques for hematocrit, within 15 minutes; glucose, blood urea nitrogen (BUN), creatinine, blood gases, routine urine analysis, complete blood count, routine blood chemistries, type & cross, Coombs test, bacterial smear within 1 hour; and capabilities for bacterial culture and sensitivity and viral culture.

RECOMMENDATIONS:

12. The hospital shall designate a physician to assume primary responsibility for initiating, supervising and reviewing the plan for management of distressed infants. Policies and procedures shall assign responsibility for the identification and resuscitation of distressed neonates to individuals who have successfully completed a neonatal resuscitation program and are both specifically trained and immediately available in the hospital at all times.

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RECOMMENDATIONS:

13. The hospital shall be responsible for assuring that staff physicians and consultants are aware of standards and guidelines in the letter of agreement.

RECOMMENDATIONS:

14. The hospital shall provide documentation of health care provider participation in Joint Mortality and Morbidity reviews.

RECOMMENDATIONS:

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX M Level II Resource Checklist**

**Level II Resource Checklist**  
**Briefly describe institutional compliance:**

The Level II hospital shall provide all of the services outlined for Level I general care.

1. The hospital shall provide continuing education for medical, nursing, respiratory therapy and other staff who provide general perinatal services, with evidence of a yearly competence assessment appropriate to the population served.

RECOMMENDATIONS:

2. The hospital shall provide documentation of participation in Continuous Quality Improvement (CQI) implemented by the Administrative Perinatal Center.

RECOMMENDATIONS:

3. The hospital shall provide documentation of the health care provider's risk assessment and consultation with a maternal-fetal medicine sub-specialist or neonatologist as specified in the letter of agreement and hospital's policies and procedures, and transfer to the appropriate level of care.

RECOMMENDATIONS:

4. The hospital shall provide documentation of the availability of trained personnel and facilities to provide competent emergency obstetric and newborn care.

RECOMMENDATIONS:

5. The hospital shall maintain a system of recording admissions, discharges, birth weight, outcome, complications and transports to meet the requirement to support CQI activities described in the hospital's letter of agreement with the Administrative Perinatal Center. The hospital shall comply with the reporting requirements of the State Perinatal Reporting System.

RECOMMENDATIONS:

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6. The hospital shall provide documentation of the capability for continuous electronic maternal-fetal monitoring for patients identified at risk with staff available 24 hours a day, including physicians and nursing, who are knowledgeable of electronic fetal monitoring use and interpretation. Staff shall complete a competence assessment in electronic maternal-fetal monitoring every two years.

RECOMMENDATIONS:

7. The hospital shall have the capability of performing caesarean sections within 30 minutes of decision to incision.

RECOMMENDATIONS:

8. The hospital shall have experienced blood bank technicians immediately available in the hospital for blood banking procedures and identification of irregular antibodies. Blood component therapy shall be readily available.

RECOMMENDATIONS:

9. The hospital shall have general anesthesia services on call and available under 30 minutes to initiate C-section.

RECOMMENDATIONS:

10. The hospital shall have experienced radiology technicians immediately available in the hospital with professional interpretation available 24 hours a day. Ultrasound capability shall be available 24 hours a day. In addition, Level I ultrasound and staff knowledgeable in its use and interpretation shall be available 24 hours a day.

RECOMMENDATIONS:

11. The hospital shall have the following clinical laboratory resources available:

Micro-techniques for hematocrit and blood gases within 15 minutes; glucose, blood urea nitrogen (BUN), creatinine, blood gases, routine urine analysis, electrolytes and coagulation studies, complete blood count, routine blood chemistries, type & cross, Coombs' test, bacterial smear within 1 hour; and capabilities for bacterial culture and sensitivity and viral culture.

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RECOMMENDATIONS:

- 12. The hospital shall designate a physician to assume primary responsibility for initiating, supervising and reviewing the plan for management of distressed infants. Policies and procedures shall assign responsibility for the identification and resuscitation of distressed neonates to individuals who have successfully completed a neonatal resuscitation program and are both specifically trained and immediately available in the hospital at all times.

RECOMMENDATIONS:

- 13. The hospital shall ensure that personnel skilled in phlebotomy and IV placement in newborns are available 24 hours a day.

RECOMMENDATIONS:

- 14. Social worker services shall be provided by one social worker, with relevant experience and responsibility for perinatal patients, and available through the hospital social work department.

RECOMMENDATIONS:

- 15. The hospital shall ensure that protocols for discharge planning, routine follow-up care, and developmental follow-up are established.

RECOMMENDATIONS:

- 16. The hospital shall ensure that a licensed respiratory care practitioner with experience in neonatal care is available 24 hours a day.

RECOMMENDATIONS:

- 17. The hospital shall ensure that a dietitian with experience in perinatal nutrition is available to plan diets to meet the needs of mothers and infants.

RECOMMENDATIONS:

- 18. The hospital shall ensure that staff physicians and consultants are aware of standards and guidelines in the letter of agreement.

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RECOMMENDATIONS:

19. The hospital shall provide documentation of health care provider participation in Joint Mortality and Morbidity reviews.

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX N Level II with Extended Neonatal Capabilities Resource Checklist**

**Level II with Extended Neonatal Capabilities Resource Checklist**

**Briefly describe institutional compliance:**

1. The hospital shall provide documentation that the obstetrical activities are directed and supervised by a full-time board-certified obstetrician or a licensed osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Obstetricians and Gynecologists.

RECOMMENDATIONS:

2. The hospital shall provide documentation that the neonatal activities are directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal Medicine or a licensed osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Pediatricians.

RECOMMENDATIONS:

3. The directors of obstetrics and neonatal services shall ensure back-up supervision of their services when they are unavailable.

RECOMMENDATIONS:

4. The hospital shall provide documentation that the obstetric-newborn nursing service is directed by a full-time nurse experienced in perinatal nursing, preferably with a master's degree.

RECOMMENDATIONS:

5. The hospital shall provide documentation that the pediatric-neonatal respiratory therapy services are directed by a full-time licensed respiratory care practitioner with a bachelor's degree.

RECOMMENDATIONS:

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6. The hospital shall provide documentation that the practitioner responsible for the Special Care Nursery has at least three years experience in all aspects of pediatric and neonatal respiratory therapy and completion of the neonatal/pediatric specialty examination of the National Board for Respiratory Care.

RECOMMENDATIONS:

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7. Preventive services shall be designed to prevent, detect, diagnose and refer or treat conditions known to occur in the high-risk newborn, such as cerebral hemorrhage, visual defects (retinopathy of prematurity) and hearing loss, and to provide appropriate immunization of high-risk newborns.

RECOMMENDATIONS:

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8. The hospital shall ensure that a person is designated to coordinate the local health department community nursing follow-up process, to direct discharge planning, to make home care arrangements, to track discharged patients, and to collect outcome information. The community nursing referral process shall consist of notifying the high-risk follow-up nurse in whose jurisdiction the patient resides. The Illinois Department of Human Services will identify and update referral resources for the area served by the unit.

RECOMMENDATIONS:

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9. The hospital shall provide documentation that the Level II hospital with Extended Neonatal Capabilities has developed, with the assistance of the Administrative Perinatal Center, a referral agreement with a neonatal follow-up clinic to provide neuro-developmental assessment and outcome data on the neonatal population. Institutional policies and procedures shall describe the at-risk population and referral procedure to be followed.

RECOMMENDATIONS:

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10. The hospital shall ensure that if the Level II hospital with Extended Neonatal Capabilities transports neonatal patients, the hospital complies with Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians.

RECOMMENDATIONS:

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To provide for assisted ventilation of newborn infants beyond immediate stabilization:

1. The hospital shall provide documentation that a pediatrician or advanced practice nurse, whose professional staff privileges granted by the hospital specifically include the management of critically ill infants and newborns receiving assisted ventilation, a pediatrician receiving post-graduate training in a neonatal-perinatal medicine fellowship program accredited by the Accreditation Council of Graduate Medical Education or an active candidate or board-certified neonatologist is present in the hospital the entire time that the infant is receiving assisted ventilation. If infants are receiving on-site assisted ventilation care from an advance practice nurse or a physician who is not a neonatologist, a board-certified neonatologist or active candidate neonatologist shall be available on call to assist in the care of those infants as needed.

RECOMMENDATIONS:

2. The hospital shall provide suitable backup systems and planning to prevent and respond appropriately to sudden power outage, oxygen system failure, and interruption of medical grade compressed air delivery.

RECOMMENDATIONS:

3. The hospital shall provide documentation that the nurses caring for infants who are receiving assisted ventilation have documented competence and experience in the care of such infants.

RECOMMENDATIONS:

4. The hospital shall provide documentation that the licensed respiratory care practitioner has documented competence and experience in the care of the infants who are receiving assisted ventilation and is also available to the Special Care Nursery during the entire time that the infant receives assisted ventilation.

RECOMMENDATIONS:

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

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**Section 640.APPENDIX O Level III Resource Checklist**

**Level III Resource Checklist**

**Briefly describe institutional compliance:**

The Level III hospital shall provide all of the services outlined for Level I and Level II general, intermediate and special care, as well as diagnosis and treatment of high-risk pregnancy and neonatal problems. Both the obstetrical and neonatal services shall achieve Level III capability for Level III designation.

**Level III General Provisions**

- 1. The hospital shall provide documentation of participation in Continuous Quality Improvement (CQI) implemented by the Administrative Perinatal Center.

RECOMMENDATIONS:

- 2. The hospital shall provide documentation of health care provider participation in Joint Morbidity & Mortality Reviews.

RECOMMENDATIONS:

- 3. The hospital shall have the following clinical laboratory resources available:

Microtechniques for hematocrit and blood gases within 15 minutes; glucose, blood urea nitrogen (BUN), creatinine, blood gases, routine urine analysis, electrolytes and coagulation studies, complete blood count, routine blood chemistries, type & cross, Coombs test, bacterial smear within one hour; and capabilities for bacterial culture and sensitivity and viral culture.

RECOMMENDATIONS:

- 4. The hospital shall ensure that experienced radiology technicians are immediately available in the hospital with professional interpretation available 24 hours a day. Ultrasound capability shall be available 24 hours a day with additional ultrasound availability on the OB floor and staff knowledgeable in its interpretation.

RECOMMENDATIONS:

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5. The hospital shall provide blood bank technicians immediately available in the hospital for blood banking procedures and identification of irregular antibodies. Blood components shall be readily available.

RECOMMENDATIONS: \_\_\_\_\_

6. The hospital shall ensure that personnel skilled in phlebotomy and IV placement in newborns are available 24 hours a day.

RECOMMENDATIONS: \_\_\_\_\_

**Level III Standards**

1. The Level III hospital shall provide documentation of a policy requiring health care professionals, in both obstetrics and pediatrics, to obtain consultation from or transfer of care to the maternal-fetal medicine or neonatology sub-specialists as outlined in the standards for Level II.

RECOMMENDATIONS: \_\_\_\_\_

2. The Level III hospital shall accept all medically eligible Illinois residents. Medical eligibility is to be determined by the obstetrical or neonatal director or his/her designee based on the Criteria for High-Risk Identification (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists).

RECOMMENDATIONS: \_\_\_\_\_

3. The Level III hospital shall provide or facilitate emergency transportation of patients referred to the hospital in accordance with guidelines for inter-hospital care of the perinatal patient (Guidelines for Perinatal Care, American Academy of Pediatrics and American College of Obstetricians and Gynecologists). If the Level III hospital is unable to accept the patient referred, the Administrative Perinatal Center shall arrange for placement at another Level III hospital or appropriate Level II or Level II hospital with Extended Neonatal Capabilities.

RECOMMENDATIONS: \_\_\_\_\_

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4. The Level III hospital that elects not to provide all of the advanced level services shall have established policies and procedures for transfer of these mothers and infants to a hospital that can provide the service needed as outlined in the letter of agreement.

RECOMMENDATIONS:

5. The Level III hospital shall have a clearly identifiable telephone number, facsimile number and/or other electronic communication, either a special number or a specific extension answered by unit personnel, for receiving consultation requests and requests for admissions. This number shall be kept current with the Department and with the Regional Perinatal Network.

RECOMMENDATIONS:

6. The Level III hospital shall provide and document continuing education for medical, nursing, respiratory therapy, and other staff providing general, intermediate and intensive care perinatal services.

RECOMMENDATIONS:

7. The Level III hospital shall provide caesarean section decision-to-incision within 30 minutes.

RECOMMENDATIONS:

8. The hospital shall provide data relating to activities and shall comply with the requirements of the State Perinatal Reporting System.

RECOMMENDATIONS:

9. The medical co-directors of the Level III hospital shall be responsible for developing a system ensuring adequate physician-to-physician communication. Communication with referring physicians of patients admitted shall be sufficient to report patient progress before and at the time of discharge.

RECOMMENDATIONS:

10. The hospital shall provide documentation of the capability for continuous electronic maternal-fetal monitoring for patients identified at risk with staff available 24 hours a

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day, including physicians and nursing, who are knowledgeable of electronic fetal monitoring use and interpretation. Staff shall complete a competence assessment in electronic maternal-fetal monitoring every two years.

RECOMMENDATIONS:

11. The Level III hospital, in collaboration with the Administrative Perinatal Center, shall establish policies and procedures for the return transfer of high-risk mothers and infants to the referring hospital when they no longer require the specialized care and services of the Level III hospital.

RECOMMENDATIONS:

12. The Level III hospital shall provide suitable backup systems and planning to prevent and respond to a sudden power outage, oxygen system failure, and interruption of medical grade compressed air delivery.

RECOMMENDATIONS:

13. The Level III hospital shall provide or develop a referral agreement with a follow-up clinic to provide neuro-developmental services for the neonatal population. Hospital policies and procedures shall describe the at-risk population and the referral procedure to be followed for enrolling the infant in developmental follow-up. Infants shall be scheduled for assessments at regular intervals. Neuro-developmental assessments shall be communicated to the primary physicians. Referrals shall be made for interventional care in order to minimize neurological sequelae. A system shall be established to track, record and report neuro-developmental outcome data for the population, as required to support network CQI activities.

RECOMMENDATIONS:

14. Neonatal surgical services shall be available 24 hours a day.

RECOMMENDATIONS:**Level III Resource Requirements**

1. The Level III hospital shall provide documentation that obstetrical activities shall be directed and supervised by a full-time subspecialty obstetrician certified by the American

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Board of Obstetrics and Gynecology in the subspecialty of maternal-fetal medicine or a licensed osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Obstetricians and Gynecologists. The director of obstetric services shall ensure the back-up supervision of his or her services by a physician with equivalent credentials.

RECOMMENDATIONS:

2. The Level III hospital shall provide documentation that neonatal activities shall be directed and supervised by a full-time pediatrician certified by the American Board of Pediatrics Sub-Board of Neonatal/Perinatal Medicine or a licensed osteopathic physician with equivalent training and experience and certification by the American Osteopathic Board of Pediatricians/Neonatal-Perinatal Medicine. The director shall ensure the back-up supervision of his or her services by a physician with equivalent credentials.

RECOMMENDATIONS:

3. The Level III hospital shall provide documentation that an administrator/manager with a master's degree shall direct, in collaboration with the medical directors, the planning, development and operation of the non-medical aspects of the Level III hospital and its programs and services.

RECOMMENDATIONS:

4. The Level III hospital shall provide documentation that the obstetric and newborn nursing services are directed by a full-time nurse experienced in perinatal nursing with a master's degree.

RECOMMENDATIONS:

5. The Level III hospital shall provide documentation that half of all neonatal intensive care direct nursing care hours are provided by registered nurses who have had two years or more nursing experience in a Level III NICU. All NICU direct nursing care hours shall be provided or supervised by licensed registered nurses who have advanced neonatal intensive care training and documented competence in neonatal pathophysiology and care technologies used in the NICU. All nursing staff working in the NICU shall have yearly competence assessment in neonatal intensive care nursing.

RECOMMENDATIONS:

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6. The Level III hospital shall provide documentation that obstetrical anesthesia services, under the supervision of a board-certified anesthesiologist with training in maternal, fetal and neonatal anesthesia, are available 24 hours a day. The director of obstetric anesthesia shall ensure the back-up supervision of his or her services when he or she is unavailable.

RECOMMENDATIONS:

7. The Level III hospital shall provide documentation that pediatric-neonatal respiratory therapy services are directed by a full time licensed respiratory care practitioner with a bachelor's degree.

RECOMMENDATIONS:

8. The Level III hospital shall provide documentation that the respiratory care practitioner responsible for the NICU has at least three years of experience in all aspects of pediatric and neonatal respiratory care at a Level III Neonatal Intensive Care Unit and completion of the neonatal/pediatrics specialty examination of the National Board for Respiratory Care.

RECOMMENDATIONS:

9. The Level III hospital shall provide documentation that respiratory care practitioners with experience in neonatal ventilatory care staff the NICU according to the respiratory care requirements of the patient population, with a minimum of one dedicated neonatal licensed respiratory care practitioner for newborns on assisted ventilation, and with additional staff provided as necessary to perform other neonatal respiratory care procedures.

RECOMMENDATIONS:

10. The Level III hospital shall provide documentation that a physician for the program assumes primary responsibility for initiating, supervising and reviewing the plan for management of distressed infants in the delivery room. Hospital policies and procedures shall assign responsibility for identification and resuscitation of distressed neonates to individuals who are both specifically trained and immediately available in the hospital at all times. Capability to provide neonatal resuscitation in the delivery room may be

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satisfied by current completion of a neonatal resuscitation program by medical, nursing and respiratory care staff or a rapid response team.

RECOMMENDATIONS:

- 11. The Level III hospital shall provide documentation that a board-certified or active candidate obstetrician is present and available in the hospital 24 hours a day. Maternal-fetal medicine consultation shall be available 24 hours a day.

RECOMMENDATIONS:

- 12. The Level III hospital shall provide documentation that a board-certified neonatologist, active candidate neonatologist or a pediatrician receiving postgraduate training in a neonatal-perinatal medicine fellowship program accredited by the Accreditation Council of Graduate Medical Education is present and available in the hospital 24 hours a day to provide care for newborns in the NICU.

RECOMMENDATIONS:

- 13. The Level III hospital shall provide documentation that neonatal surgical services are supervised by a board-certified surgeon or active candidate in pediatric surgery appropriate for the procedures performed at the Level III hospital.

RECOMMENDATIONS:

- 14. The Level III hospital shall provide documentation that neonatal surgical anesthesia services under the direct supervision of a board-certified anesthesiologist with extensive training or experience in pediatric anesthesiology are available 24 hours a day.

RECOMMENDATIONS:

- 15. The Level III hospital shall provide documentation that neonatal neurology services, under the direct supervision of a board-certified or active candidate pediatric neurologist, are available for consultation in the NICU 24 hours a day.

RECOMMENDATIONS:

- 16. The Level III hospital shall provide documentation that neonatal radiology services, under the direct supervision of a board-certified radiologist with extensive training or

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experience in neonatal radiographic and ultrasound interpretation, are available 24 hours a day.

RECOMMENDATIONS:

17. The Level III hospital shall provide documentation that neonatal cardiology services, under the direct supervision of an active candidate pediatrician or a pediatrician board-certified by the American Board of Pediatrics Sub-Board of Pediatric Cardiology, are available for consultation 24 hours a day. In addition, cardiac ultrasound services and pediatric cardiac catheterization services by staff with specific training and experience shall be available 24 hours a day.

RECOMMENDATIONS:

18. The Level III hospital shall provide documentation that a board-certified or active candidate ophthalmologist with experience in the diagnosis and treatment of the visual problems of high-risk newborns (retinopathy of prematurity) is available for appropriate examinations, treatment and follow-up care of high-risk newborns.

RECOMMENDATIONS:

19. The Level III hospital shall provide documentation that pediatric sub-specialists with specific training and extensive experience or subspecialty board certification or active candidacy (when applicable) are available 24 hours a day, including, but not limited to, pediatric urology, pediatric otolaryngology, neurosurgery, pediatric cardiothoracic surgery and pediatric orthopedics appropriate for the procedures performed at the Level III hospital.

RECOMMENDATIONS:

20. The Level III hospital shall provide documentation that genetic counseling services are available for inpatients and outpatients, and the hospital shall provide for genetic laboratory testing, including, but not limited to, chromosomal analysis and banding, fluorescence in situ hybridization (FISH), and selected allele detection.

RECOMMENDATIONS:

21. The Level III hospital shall designate at least one person to coordinate the community nursing follow-up referral process, to direct discharge planning, to make home care

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arrangements, to track discharged patients, and to ensure appropriate enrollment in a developmental follow-up program. The community nursing referral process shall consist of notifying the follow-up nurse in whose jurisdiction the patient resides of discharge information on all patients. The Illinois Department of Human Services will identify and update referral resources for the area served by the unit.

RECOMMENDATIONS:

22. The Level III hospital shall establish a protocol that defines educational criteria necessary for commonly required home care modalities, including, but not limited to, continuous oxygen therapy, electronic cardio-respiratory monitoring, technologically assisted feeding and intravenous therapy.

RECOMMENDATIONS:

23. The Level III hospital shall provide documentation that one or more full-time licensed medical social workers with perinatal/neonatal experience are dedicated to the Level III hospital.

RECOMMENDATIONS:

24. The Level III hospital shall provide documentation that one registered pharmacist with experience in perinatal pharmacology is available for consultation on therapeutic pharmacology issues 24 hours a day.

RECOMMENDATIONS:

25. The Level III hospital shall provide documentation that one dietitian with experience in perinatal nutrition is available to plan diets and education to meet the special needs of high-risk mothers and neonates in both inpatient and outpatient settings.

RECOMMENDATIONS:

(Source: Added at 35 Ill. Reg. 2583, effective January 31, 2011)

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: The Administration and Operation of the Teachers' Retirement System
- 2) Code Citation: 80 Ill. Adm. Code 1650
- 3) 

<u>Section Numbers:</u>	<u>Adopted:</u>
1650.180	Amended
1650.450	Amended
- 4) Statutory Authority: Implementing and authorized by Article 16 of the Illinois Pension Code [40 ILCS 5/16]
- 5) Effective Date of Amendments: January 25, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any material incorporated by reference, are on file in the Teachers' Retirement System's principal office and are available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: July 16, 2010; 34 Ill. Reg. 9743
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: Various punctuation changes recommended by JCAR were made in the final version.
- 12) Have all the changes agreed upon by the agency and JCAR been as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? Yes

<u>Section Number:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
1650.481	Amendment	34 Ill. Reg. 12145; August 20, 2010

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- 15) Summary and Purpose of Rulemaking: 1650.180 is amended to implement TRS' new mandatory web-based Employer's annual report of earnings system. Section 1650.450 is amended because, based upon recent guidance from the IRS regarding non-qualified deferred compensation arrangements, TRS staff no longer feels the need to ensure validity at the TRS level.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

Thomas S Gray, General Counsel  
Teachers' Retirement System  
2815 West Washington, P.O. Box 19253  
Springfield, Illinois 62794-9253

217/753-0375

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

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## NOTICE OF ADOPTED AMENDMENTS

## TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES

## SUBTITLE D: RETIREMENT SYSTEMS

## CHAPTER III: TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

## PART 1650

THE ADMINISTRATION AND OPERATION OF THE  
TEACHERS' RETIREMENT SYSTEM

## SUBPART A: REPORTS BY BOARD OF TRUSTEES

## Section

1650.10 Annual Financial Report (Repealed)

## SUBPART B: BASIC RECORDS AND ACCOUNTS

## Section

1650.110 Membership Records  
1650.120 Claims Records (Repealed)  
1650.130 Individual Accounts (Repealed)  
1650.140 Ledger and Accounts Books (Repealed)  
1650.150 Statistics (Repealed)  
1650.160 Confidentiality of Records  
1650.180 Filing and Payment Requirements  
1650.181 Early Retirement Incentive Payment Requirements (Repealed)  
1650.182 Waiver of Additional Amounts Due  
1650.183 Definition of Employer's Normal Cost

## SUBPART C: FILING OF CLAIMS

## Section

1650.201 Disability Benefits – Application Procedure; Effective Date  
1650.202 Disability Benefits – Definitions  
1650.203 Disability Retirement Annuity – Definitions  
1650.204 Gainful Employment – Consequences  
1650.205 Medical Examinations and Investigation of Disability Claims  
1650.206 Physician Certificates  
1650.207 Disability Due to Pregnancy  
1650.208 Disability Payments  
1650.209 Computation of Annual Salary When Member Has Different Semester Salary

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

## NOTICE OF ADOPTED AMENDMENTS

	Rates (Repealed)
1650.210	Claim Applications
1650.211	Disability Recipient Eligible to Receive an Age or Disability Retirement Annuity
1650.220	Reclassification of Disability Claim (Repealed)
1650.221	When Member Becomes Annuitant
1650.222	Death Out of Service
1650.230	Medical Examinations and Investigations of Claims (Repealed)
1650.240	Refunds; Canceled Service; Repayment
1650.250	Death Benefits
1650.260	Evidence of Age
1650.270	Reversionary Annuity – Evidence of Dependency
1650.271	Evidence of Parentage
1650.272	Eligible Child Dependent By Reason of a Physical or Mental Disability
1650.280	Evidence of Marriage
1650.290	Offsets

## SUBPART D: MEMBERSHIP AND SERVICE CREDITS

Section	
1650.301	Early Retirement Without Discount – Return to Teaching from a Break in Service
1650.310	Effective Date of Membership
1650.315	Verifying Service Credit
1650.320	Method of Calculating Service Credits
1650.325	Method of Calculating Service Credit for Recipients of a Disability Benefit or Occupational Disability Benefit
1650.330	Duplicate Service Credit
1650.335	Unreported Regular Service Credit and Earnings
1650.340	Service Credit for Leaves of Absence
1650.341	Service Credit for Involuntary Layoffs
1650.345	Service Credit for Periods Away From Teaching Due to Pregnancy
1650.346	Service Credit for Periods Away From Teaching Due to Adoption
1650.350	Service Credit for Unused Accumulated Sick Leave Upon Retirement
1650.351	Employer Contribution for Excess Sick Leave
1650.355	Purchase of Optional Service – Required Minimum Payment
1650.356	Payroll Deduction Program (Repealed)
1650.357	Employer Payment of Member's Optional Service and/or Upgrade Contribution Balance (Repealed)
1650.360	Settlement Agreements and Judgments
1650.370	Calculation of Average Salary (Renumbered)

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- 1650.380 Definition of Actuarial Equivalent (Repealed)
- 1650.390 Independent Contractors
- 1650.391 Optional 2.2 Upgrade of Earned and Credited Service
- 1650.392 2.2 Upgrade of Optional Service Not Credited at Initial Upgrade

## SUBPART E: CONTRIBUTION CREDITS AND PAYMENTS

## Section

- 1650.410 Return of Contributions for Duplicate or Excess Service
- 1650.415 Return of Optional Increase in Retirement Annuity Contributions
- 1650.416 Optional Increase in Retirement Annuity – 1% Contribution Reduction
- 1650.417 Mandatory Distributions Pursuant to Section 401(a)(9) of the Internal Revenue Code
- 1650.420 Interest on Deficiencies (Repealed)
- 1650.430 Installment Payments (Repealed)
- 1650.440 Small Deficiencies, Credits or Death Benefit Payments (Repealed)
- 1650.450 Compensation Recognized As "Salary"
- 1650.451 Reporting of Conditional Payments
- 1650.460 Calculation of Average Salary
- 1650.470 Rollover Distributions
- 1650.480 Rollovers to the System
- 1650.481 Employer Contribution Required for Salary Increases in Excess of 6%
- 1650.482 Contracts and Collective Bargaining Agreements – Loss of Exemption from Employer Contributions
- 1650.483 Employer Contributions for Salary Increases in Excess of 6% and Excess Sick Leave Exemption from Contributions
- 1650.484 Members Not Covered by Collective Bargaining Agreements or Employment Contracts
- 1650.485 Employer Contributions for Salary Increases in Excess of 6% – Receipt of Bill

## SUBPART F: ANNUITANTS AND BENEFICIARIES

## Section

- 1650.505 Beneficiary (Repealed)
- 1650.510 Re-entry Into Service (Repealed)
- 1650.511 Separation from Service
- 1650.512 Verification of Compliance with Post-Retirement Employment Limitations
- 1650.520 Suspension of Benefits
- 1650.530 Power of Attorney

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1650.540	Conservators/Guardians
1650.550	Presumption of Death
1650.560	Benefits Payable on Death
1650.561	Valid Beneficiary Designations
1650.570	Survivors' Benefits
1650.571	Payment of Monthly Survivor Benefits to a Trust
1650.575	Full-time Student – Receipt of Survivors Benefits Until Age 22
1650.580	Evidence of Eligibility
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1650.605	Policy of the Board Concerning Attorney Generals' Opinion (Repealed)

## SUBPART H: ADMINISTRATIVE REVIEW

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1650.610	Staff Responsibility
1650.620	Right of Appeal
1650.630	Form of Written Request
1650.635	Presiding Hearing Officer – Duties and Responsibilities
1650.640	Prehearing Procedure
1650.641	Claims Hearing Committee Hearing Packet
1650.650	Hearing Procedure
1650.660	Rules of Evidence (Repealed)

## SUBPART I: AMENDMENTS TO BYLAWS AND RULES

Section	
1650.710	Amendments

## SUBPART J: RULES OF ORDER

Section	
1650.810	Parliamentary Procedure

## SUBPART K: PUBLIC RECORD REQUESTS

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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## Section

1650.910	Summary and Purpose (Repealed)
1650.920	Definitions (Repealed)
1650.930	Submission of Requests
1650.940	Form and Content of FOIA Requests (Repealed)
1650.950	Appeal of a Denial (Repealed)
1650.960	Executive Director's Response to Appeal (Repealed)
1650.970	Response to FOIA Requests (Repealed)
1650.980	Inspection of Records at System Office
1650.990	Copies of Public Records
1650.995	Materials Immediately Available

## SUBPART L: BOARD ELECTION PROCEDURES

## Section

1650.1000	Nomination of Candidates
1650.1001	Elections Date/Election Day – Defined
1650.1010	Petitions
1650.1020	Eligible Voters
1650.1030	Election Materials
1650.1040	Marking of Ballots
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1650.1060	Observation of Ballot Counting
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1650.1080	Challenges to Ballot Counting
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## SUBPART M: QUALIFIED ILLINOIS DOMESTIC RELATIONS ORDERS

## Section

1650.1110	Definitions
1650.1111	Requirements for a Valid Qualified Illinois Domestic Relations Order
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1650.1114	Filing a QILDRO or a Calculation Order with the System
1650.1115	Benefits Affected by a QILDRO
1650.1116	Effect of a Valid QILDRO
1650.1117	QILDROs Against Persons Who Became Members Prior to July 1, 1999

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1650.1118	Alternate Payee's Address
1650.1119	Electing Form of Payment
1650.1120	Automatic Annual Increases
1650.1121	Reciprocal Systems QILDRO Policy Statement (Repealed)
1650.1122	Providing Benefit Information for Divorce Purposes
1650.1123	Suspension and Expiration of a QILDRO
1650.1124	Income Tax Reporting
1650.1125	Lump-Sum Death Benefit Allocation to Alternate Payee

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1650.1200	Payroll Deduction Program Guidelines
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1650.1203	Payroll Deduction Program – Full Time Employment Defined
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SUBPART P: COMPETITIVE SELECTION PROCEDURES  
FOR INVESTMENT SERVICES

Section	
1650.3000	Summary and Purpose
1650.3005	Definitions
1650.3010	Manager Database
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1650.3020	Public Market Searches
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1650.3030	Private Market and Commingled Fund Searches
1650.3035	Private Market Real Estate Separate Account Searches
1650.3040	Consultant Searches
1650.3045	Evaluation by Investment Committee

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**AUTHORITY:** Implementing and authorized by Articles 1 and 16 of the Illinois Pension Code [40 ILCS 5/Arts. 1 and 16]; Freedom of Information Act [5 ILCS 140]; Internal Revenue Code (26 USC 1 et seq.); Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15].

**SOURCE:** Filed June 20, 1958; emergency rules adopted at 2 Ill. Reg. 49, p. 249, effective November 29, 1978, for a maximum of 150 days; adopted at 3 Ill. Reg. 9, p. 1, effective March 3, 1979; codified at 8 Ill. Reg. 16350; amended at 9 Ill. Reg. 20885, effective December 17, 1985; amended at 12 Ill. Reg. 16896, effective October 3, 1988; amended at 14 Ill. Reg. 18305, effective October 29, 1990; amended at 15 Ill. Reg. 16731, effective November 5, 1991; amended at 17 Ill. Reg. 1631, effective January 22, 1993; amended at 18 Ill. Reg. 6349, effective April 15, 1994; emergency amendment at 18 Ill. Reg. 8949, effective May 24, 1994, for a maximum of 150 days; emergency modified at 18 Ill. Reg. 12880; amended at 18 Ill. Reg. 15154, effective September 27, 1994; amended at 20 Ill. Reg. 3118, effective February 5, 1996; emergency amendment at 21 Ill. Reg. 483, effective January 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 2422, effective January 31, 1997; amended at 21 Ill. Reg. 4844, effective March 27, 1997; emergency amendment at 21 Ill. Reg. 17159, effective December 9, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 7243, effective April 9, 1998; emergency amendment at 22 Ill. Reg. 7314, effective April 9, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 9374, effective May 14, 1998, for a maximum of 150 days; emergency rule modified in response to JCAR Objection at 22 Ill. Reg. 11640; emergency amendment at 22 Ill. Reg. 13151, effective June 29, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 15620, effective August 17, 1998; amended at 22 Ill. Reg. 19079, effective October 1, 1998; amended at 22 Ill. Reg. 22090, effective December 1, 1998; amended at 23 Ill. Reg. 3079, effective February 23, 1999; amended at 24 Ill. Reg. 2440, effective January 27, 2000; amended at 24 Ill. Reg. 10300, effective June 26, 2000; amended at 25 Ill. Reg. 203, effective December 22, 2000; amended at 26 Ill. Reg. 2758, effective February 11, 2002; amended at 26 Ill. Reg. 11476, effective July 11, 2002; amended at 27 Ill. Reg. 1668, effective January 17, 2003; amended at 27 Ill. Reg. 9209, effective May 28, 2003; amended at 28 Ill. Reg. 10055, effective June 29, 2004; amended at 29 Ill. Reg. 1546, effective January 14, 2005; amended at 29 Ill. Reg. 13244, effective August 9, 2005; amended at 30 Ill. Reg. 194, effective December 23, 2005; amended at 30 Ill. Reg. 472, effective December 21, 2005; amended at 30 Ill. Reg. 11728, effective June 23, 2006; amended at 30 Ill. Reg. 17525, effective October 18, 2006; amended at 31 Ill. Reg. 10688, effective July 13, 2007; amended at 32 Ill. Reg. 4073, effective February 28, 2008; amended at 32 Ill. Reg. 7979, effective May 6, 2008; amended at 32 Ill. Reg. 13534, effective August 6, 2008; amended at 33 Ill. Reg. 4401, effective March 3, 2009; amended at 33 Ill. Reg. 15863, effective November 2, 2009; amended at 34 Ill. Reg. 4900, effective March 22, 2010; amended at 34 Ill. Reg. 7787, effective May 21, 2010; amended at 35

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Ill. Reg. 2413, effective January 21, 2011; amended at 35 Ill. Reg. 2788, effective January 25, 2011.

## SUBPART B: BASIC RECORDS AND ACCOUNTS

**Section 1650.180 Filing and Payment Requirements**

- a) All employers are required to forward member contributions and amounts required under [40 ILCS 5/16-158(c)] to the System after the close of each pay period or bi-monthly, if a State Institution, and to file an annual report of earnings with the System on or before August 15 of each year. Failure to forward contributions or to file reports shall result in additional amounts due as prescribed by Section 16-155 of the Illinois Pension Code (the Act) [40 ILCS 5/16-155].
- ~~b) In determining the additional amount due for late filing of the employer's annual report of earnings as prescribed by Section 16-155(c) of the Act, the postmark date is deemed to be the date of receipt. If the postmark is made other than by the U.S. Post Office, such as a postage meter, the postmark must show a date on or before the date the material was to be received in an office of the System and must be received no later than four working days after the date shown.~~
- be) The employer's annual report of earnings shall be properly completed and report creditable earnings in accordance with applicable laws and rules. Any report failing to materially conform with this requirement shall be returned to the employer and shall not be deemed received until properly corrected and returned to the System.
- ~~d) Envelopes must be properly addressed to the System if the reports are to be considered filed timely, with correct postage paid by the employer.~~
- ce) Employers ~~with 50 or more contributing members~~ are required to file the report via the System's web-based annual automated reporting system.
- df) All contributions and payments required to be remitted to the System by participating employers shall be forwarded to the System via electronic means.

(Source: Amended at 35 Ill. Reg. 2788, effective January 25, 2011)

## SUBPART E: CONTRIBUTION CREDITS AND PAYMENTS

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**Section 1650.450 Compensation Recognized As "Salary"**

- a) "Salary" means any form of creditable compensation received by a member in consideration of services rendered as a teacher, subject to all applicable limits and restrictions imposed on qualified plans under the Internal Revenue Code. "Salary" directly related to specific work performed during a school year is recognized on an accrual basis. Other creditable compensation is recognized on a cash basis. The System reserves the right to determine the year of salary recognition. The following common examples are for illustration only and do not limit the System's right to evaluate and determine other forms of creditable and non-creditable compensation.
- b) Examples of creditable compensation recognized as "salary":
  - 1) The gross amount of compensation earned or accruing to the member during the school year in a function requiring certification as a teacher.
  - 2) Additional compensation earned during the school year for the performance of extra duties, not requiring teacher certification, but which involve the supervision of students or are related to the academic program, provided the member is employed as a full-time or part-time contractual teacher and establishes active service credit in that position during the school year.
  - 3) The amount of back salary awarded to a member as a result of a settlement or judgment obtained due to a disputed dismissal, suspension or demotion. Court costs, attorney's fees, other compensatory damages and punitive damages shall not be reportable as salary. The back salary amount reported to the System under this Section shall be equal to the amount the member would have earned had the dispute not occurred, regardless of the actual amount paid.
  - 4) Lump-sum payments (e.g., retirement incentives, bonuses, payments for unused vacation and sick days) received by the member or becoming due and payable to the member prior to or concurrent with receipt of final paycheck for regular earnings.
  - 5) Contributions made by or on behalf of the member to qualified deferred

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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compensation plans (sections 401(a) and 457(b) of the Internal Revenue Code), salary reduction plans or tax sheltered annuities under section 403(b) of the Internal Revenue Code.

- 6) Amounts that would otherwise qualify as salary under subsections (b)(1) through (b)(5) but are not received directly by the member because they are used to finance benefit options in a flexible benefit plan; provided, however, that to be reportable, a flexible benefit plan cannot include non-qualifying deferred compensation. For the System's purposes, a flexible benefit plan is an option offered by an employer to its employees covered under the System to receive an alternative form of creditable compensation in lieu of employer-provided insurance.
- c) Examples of non-creditable compensation not recognized as "salary":
- 1) Lump-sum payments (e.g., retirement incentives, bonuses, payments for unused vacation and sick days) becoming due and payable to the member subsequent to receipt of final paycheck for regular earnings.
  - 2) Any lump sum payment made after the death of the member.
  - 3) Expense reimbursements, expense allowances, or fringe benefits unless included in a reportable flexible benefit plan.
  - 4) Any monies received by the member under the Workers' Compensation Act or the Workers' Occupational Diseases Act.
  - 5) Compensation for extra duties not requiring teacher certification performed by substitute and part-time non-contractual teachers.
  - 6) Any amount paid in lieu of discontinued or decreased non-reportable benefits, or reported in lieu of previously non-reported compensation, where the conversion occurs in the member's final seven years of service. If any form of non-creditable or non-reported compensation in any of the member's last seven creditable school years of employment exceeds that of any other subsequent year, the System will presume the difference to have been converted into salary in the subsequent year. To overcome the presumption, the member must submit documentary evidence to the System that clearly and convincingly proves that the change in

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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compensation structure was due to a change in a collectively bargained agreement applicable to all individuals covered by the agreement, a change in employer policies affecting a group of similarly situated members some of whom are not within seven years of retirement eligibility, or a change in family status, and not to increase final average salary.

- 7) Any amount paid by an employer as the employer's one time contribution (or on behalf of the employee as the employee's one-time contribution) required by the System as part of the statutory early retirement option in Section 16-133.2 of the Act.
- 8) Options to take salary in lieu of employment-related expense allowances or reimbursements.
- 9) Employer payment of the member's Teachers Health Insurance Security Fund contribution.
- 10) Commissions (i.e., payments to a member based upon a percentage formula).
- 11) Contributions to and distributions from nonqualified deferred compensation arrangements, ~~provided the employer furnishes the System an Internal Revenue Service determination letter confirming that the nonqualified deferred compensation arrangement is valid under IRC 457(f).~~
- 12) Employer contributions to and distributions from medical spending accounts.

(Source: Amended at 35 Ill. Reg. 2788, effective January 25, 2011)

## DEPARTMENT OF EMPLOYMENT SECURITY

## NOTICE OF EMERGENCY AMENDMENT

- 1) Heading of the Part: Disqualifying Income And Reduced Benefits
- 2) Code Citation: 56 Ill. Adm. Code 2920
- 3) Section Number: 2920.18                      Emergency Action: Amendment
- 4) Statutory Authority: 820 ILCS 405/234, 235, 239, 245, 401, 402, 500.1, 600, 605, 606, 610, 611, 1300, 1700 and 1701
- 5) Effective Date of Rules: January 30, 2011
- 6) If this emergency rulemaking is to expire before the end of the 150-day period, please specify the date on which it is to expire: This rulemaking has no earlier expiration date specified.
- 7) Date Filed with the Index Department: January 28, 2011
- 8) A copy of the emergency rulemaking, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: PA 96-1496, approved January 13, 2011, made changes to the individual income tax rate. The rule is being updated to correspond to the changes.
- 10) A Complete Description of the Subjects and Issues Involved: A recent amendment to the Illinois Income Tax Act (PA 96-1496) changed the tax rate for individuals. The rulemaking changes the withholding percentages for State income tax to correspond to the statutory changes and revises examples regarding the calculation of the benefits payable to claimants who have elected State or federal income tax withholding.
- 11) Are there any other proposed rulemakings to this Part pending? No
- 12) Statement of Statewide Policy Objectives: This rulemaking will not create a State mandate for units of local government.
- 13) Information and questions regarding this rulemaking shall be directed to:

Gregory J. Ramel, Deputy Legal Counsel  
Illinois Department of Employment Security

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DEPARTMENT OF EMPLOYMENT SECURITY

NOTICE OF EMERGENCY AMENDMENT

33 South State Street – Room 937  
Chicago, IL 60603

Phone: 312/793-4240  
Fax: 312/793-5645  
e-mail: [gregory.ramel@illinois.gov](mailto:gregory.ramel@illinois.gov)

The full text of the Emergency Amendment begins on the next page:

## DEPARTMENT OF EMPLOYMENT SECURITY

## NOTICE OF EMERGENCY AMENDMENT

TITLE 56: LABOR AND EMPLOYMENT  
CHAPTER IV: DEPARTMENT OF EMPLOYMENT SECURITY  
SUBCHAPTER g: INELIGIBILITY FOR BENEFITSPART 2920  
DISQUALIFYING INCOME AND REDUCED BENEFITS

## Section

2920.1	Definitions
2920.5	Ineligibility To Receive Benefits Due To Performing Full-Time Work Or Due To The Receipt Of Various Income Whose Sum Is Equal To Or Greater Than The Individual's Weekly Benefit Amount
2920.10	Reduction In Benefits Due To Receipt Of Vacation Pay, Holiday Pay, Retirement Pay, And Workers' Compensation Whose Sum Is Less Than The Individual's Weekly Benefit Amount
2920.15	Reduction In Benefits Due To Receipt Of Wages For Less Than Full-Time Work
2920.18	Voluntary Withholding For Federal And/Or State Of Illinois Income Tax
	<a href="#">EMERGENCY</a>
2920.20	Reduced Benefits: Payment Of Dependents' Allowance Or Spouse's Allowance
2920.25	Payments Made During Shutdown For Inventory Or Vacation Purposes
2920.30	Payments Made In Connection With Separation Or Layoff As, Or In The Nature Of Vacation Pay, Vacation Pay Allowance Or As Pay In Lieu Of Vacation
2920.35	Holiday Pay
2920.40	Payments In Lieu Of Notice Of Separation Or Layoff
2920.45	Severance Pay
2920.48	Residual Payments
2920.50	Back Pay Awards
2920.55	Receipt Of Or Filing For Unemployment Insurance Benefits Under The Laws Of Another State, Canada, Or The United States
2920.60	Supplemental Unemployment Benefits (SUB Pay)
2920.65	Retirement Pay
2920.66	Payments To An Election Judge
2920.68	Payments By A Labor Union
2920.69	Jury Service
2920.70	Retirement Pay Considered Disqualifying Income
2920.75	Allocation Of Retirement Pay
2920.80	Miscellaneous Forms Of Retirement Pay
2920.85	Conformity With Federal Unemployment Tax Act

## DEPARTMENT OF EMPLOYMENT SECURITY

## NOTICE OF EMERGENCY AMENDMENT

**AUTHORITY:** Implementing and authorized by Sections 234, 235, 239, 245, 401, 402, 500.1, 600, 605, 606, 610, 611, 1300, 1700 and 1701 of the Unemployment Insurance Act [820 ILCS 405/234, 235, 239, 245, 401, 402, 500.1, 600, 605, 606, 610, 611, 1300, 1700 and 1701].

**SOURCE:** Adopted at 11 Ill. Reg. 1853, effective January 7, 1987; amended at 12 Ill. Reg. 16066, effective September 23, 1988; amended at 13 Ill. Reg. 1773, effective January 27, 1989; amended at 13 Ill. Reg. 5936, effective April 18, 1989; emergency amendments at 13 Ill. Reg. 11899, effective July 1, 1989, for a maximum of 150 days; emergency amendments to 56 Ill. Adm. Code 2920.5 and 2920.75, expired November 28, 1989; amended at 13 Ill. Reg. 17402, effective October 30, 1989; amended at 15 Ill. Reg. 180, effective December 28, 1990; amended at 15 Ill. Reg. 11416, effective July 30, 1991; amended at 18 Ill. Reg. 4166, effective March 3, 1994; amended at 21 Ill. Reg. 567, effective January 1, 1997; emergency amendment at 25 Ill. Reg. 10226, effective August 7, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 15415, effective November 15, 2001; amended at 29 Ill. Reg. 1935, effective January 24, 2005; amended at 30 Ill. Reg. 2357, effective January 31, 2006; emergency amendment at 35 Ill. Reg. 2801, effective January 30, 2011, for a maximum of 150 days.

## SUBPART A: GENERAL PROVISIONS

**Section 2920.18 Voluntary Withholding For Federal And/Or State Of Illinois Income Tax**  
**EMERGENCY**

- a) Whenever an individual voluntarily elects, pursuant to Section 1300 of the Act [820 ILCS 405/1300], to have monies withheld from his unemployment insurance benefits to cover possible federal and/or State of Illinois income tax liability, the amount of benefits subject to such income tax withholding is the sum of the individual's weekly benefit amount (WBA), following any of the mandatory deductions from unemployment benefits set forth in subsections (a)(1), (2), and (3), plus any spouse or dependents' allowance payable under the Act. The following are the mandatory deductions:
- 1) disqualifying income, including vacation pay, holiday pay, retirement pay, and workers' compensation, under Section 2920.10;
  - 2) wages for less than full time work payable to him with respect to such week which are in excess of 50% of his weekly benefit amount;
  - 3) one-fifth of the individual's WBA for each day that the individual was unable or unavailable for work as required by Section 402 of the Act.

## DEPARTMENT OF EMPLOYMENT SECURITY

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- b) Whenever an individual has voluntarily elected, pursuant to Section 1300 of the Act, to have monies withheld for federal and/or State of Illinois income tax from his unemployment benefits for a period covered by a benefit ~~payment~~~~week~~, the Department shall, when withholding for federal income tax, withhold 10% of the amount of benefits that are subject to withholding under subsection (a), ~~when withholding for federal income tax~~, rounded (if not already a multiple of one dollar) to the nearest dollar and, when withholding for State of Illinois income tax, ~~withhold a percentage~~~~3%~~ of the amount of benefits that are subject to withholding under subsection (a) equal to the tax rate for individuals pursuant to the Illinois Income Tax Act~~when withholding for State of Illinois income tax~~, rounded (if not already a multiple of one dollar) to the nearest dollar. If the product is equally near 2 multiples of one dollar, it shall be rounded to the higher multiple of one dollar. If the individual's benefits for ~~a week~~~~the period~~, less amounts subject to recoupment under Section 2835.15 and less any involuntary deductions for child support pursuant to Section 2815.105, are less than the amount that would otherwise be withheld pursuant to this subsection ~~(10% of the amount of benefits subject to withholding under subsection (a) if only federal income tax withholding is elected, 3% if only State of Illinois income tax withholding is elected or 10% plus 3% if both federal and State of Illinois income tax withholding is elected)~~, the entire amount of the benefits remaining shall be withheld. If the individual elects to have both federal and State of Illinois income taxes withheld and the amount remaining is insufficient to cover both taxes, the entire amount of State of Illinois tax shall be withheld before any federal tax is withheld.
- 1) Example: The individual elects both federal and State of Illinois income tax withholding. The individual's WBA for each of the ~~two~~-weeks ending February 5, 2011, and February 12, 2011, ~~covered by the benefit payment~~ is \$251. The individual receives a dependents' allowance of \$81 for each week. ~~The amount of benefits subject to federal and State of Illinois income tax withholding for the two week period is the sum of \$332 and \$332, which equals \$664.~~ The Department will deduct for federal income tax withholding 10% of ~~\$332 for each week~~~~664~~ which equals ~~\$33.20~~~~66.40~~, which, rounded to the nearest dollar, is ~~\$33~~~~66~~. Additionally, the Department will deduct for State of Illinois income tax withholding ~~53%~~ (the tax rate for individuals pursuant to the Illinois Income Tax Act for the 2 weeks in question) of ~~\$332~~~~664~~, which equals ~~\$16.60 for each week~~~~19.92~~, which, rounded to the nearest dollar, is ~~\$17~~~~20~~. Accordingly,

## DEPARTMENT OF EMPLOYMENT SECURITY

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the individual will receive \$~~564~~<sup>578</sup> in benefits for the 2 week period after having \$66 deducted for federal income tax withholding and \$~~342~~<sup>0</sup> deducted for State of Illinois income tax withholding.

- 2) Example: The individual elects both federal and State of Illinois income tax withholding. The individual's WBA for each of the weeks ending February 5, 2011 and February 12, 2011 ~~each of the two weeks covered by the Department's payment of benefits~~ is \$129. The individual receives a dependents' allowance of \$42 for each week.

For the first week of the payment period, the individual has \$90 in disqualifying vacation pay, but in the second week the individual does not have any disqualifying vacation pay.

The amount of benefits subject to federal and State of Illinois income tax withholding for the first week is \$129 less \$90 in vacation pay, which equals \$39 plus his dependents' allowance of \$42, which totals \$81. Because the individual did not receive any disqualifying vacation pay for the second week of the period, the amount of benefits subject to federal and State of Illinois income tax withholding attributable to the second week is \$129 plus his dependents' allowance of \$42, which totals \$171.

~~The amount of benefits subject to federal and State of Illinois income tax withholding for the two week period is the sum of \$81 and \$171, which equals \$252.~~ The Department will deduct for federal income tax withholding 10% of \$~~81 for the first week~~<sup>252</sup>, which equals \$~~8.10~~<sup>25.20</sup>, which, rounded to the nearest dollar, is \$~~8~~<sup>25</sup>. The Department will deduct for State of Illinois income tax withholding ~~53%~~ (the tax rate for individuals pursuant to the Illinois Income Tax Act for the 2 weeks in question) of \$~~81~~<sup>252</sup>, which equals \$~~4.057~~<sup>56</sup>, which, rounded to the nearest dollar, is \$~~4~~<sup>8</sup>.

The individual will receive \$~~692~~<sup>49</sup> for the first week period after having \$~~82~~<sup>5</sup> deducted for federal income tax withholding and \$~~48~~ deducted for State of Illinois income tax withholding.

The Department will deduct for federal income tax withholding 10% of \$171 for the second week, which equals \$17.10, which, rounded to the nearest dollar, is \$17. The Department will deduct for State of Illinois

## DEPARTMENT OF EMPLOYMENT SECURITY

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income tax withholding 5% of \$171, which equals \$8.55, which, rounded to the nearest dollar, is \$9. The individual will receive \$145 for the second week after having \$17 deducted for federal income tax withholding and \$9 deducted for State of Illinois income tax withholding. The individual's payment for the two week period will be \$214.

- 3) Example: The individual's WBA for each of the weeks ending February 5, 2011 and February 12, 2011 ~~each of the two weeks covered by the Department's payment of benefits~~ is \$129. The amount of benefits subject to federal and State of Illinois income tax withholding for each week of the two week period is \$129. ~~The amount of benefits subject to federal and State of Illinois income tax withholding for the two week period is \$258, the sum of \$129 and \$129.~~

10% of \$~~129258~~ equals \$~~12.902580~~, which, rounded to the nearest dollar, is \$~~1326~~. ~~53%~~ of \$~~129258~~ equals \$~~6.45774~~, which, rounded to the nearest dollar, is \$~~68~~.

In this example, assume that the individual has elected both federal and State of Illinois income tax withholding, that the individual is also subject to recoupment for both weeks in an amount up to 25% of his WBA, which amount is \$32.25 for both weeks, and that the individual is subject to a withholding order of \$100 for child support for the first week.

For the first week, the Department will first recoup the entire amount of \$32.25 due for that first week. \$129 minus \$32.25 equals \$96.75. Because the individual does not have sufficient benefits to cover the full amount of child support due for that first week, the Department will deduct \$96.75, the amount of benefits available for that week. The individual's payment for the two week period will not include any benefits with respect to that first week.

For the second week of the payment period, the individual is not subject to a withholding order for child support. Accordingly, the individual is eligible to receive \$96.75 for the second week, the difference between the benefits payable to him for that week (\$129) and the amount recouped (\$32.25). Because the individual has elected both federal and State of Illinois income tax withholding for the period covered by the payment, the Department will deduct \$1326 for federal income tax withholding and \$68

## DEPARTMENT OF EMPLOYMENT SECURITY

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for State of Illinois income tax withholding from the individual's benefits and pay the individual the remaining ~~\$77.75~~62.75.

- 4) Example: Assume the same situation described in subsection (b)(3), except that the individual's withholding for court ordered child support is \$90 for each week. The amount of benefits subject to federal and State of Illinois income tax withholding for the two week period remains the same~~\$258. 10% of \$258 equals \$25.80, which, rounded to the nearest dollar, is \$26. 3% of \$258 equals \$7.74, which, rounded to the nearest dollar, is \$8.~~

The individual has sufficient benefits for the Department to recoup the maximum amount and to deduct for child support in full for both weeks. If the individual had not elected to withhold federal and State of Illinois income tax, the individual would have received ~~a check for~~ \$13.50, the sum of \$6.75 and \$6.75 for ~~each that two~~ week ~~period~~. Because the individual has elected federal and State of Illinois income tax withholding for this period and because the benefits for the period after recoupment and child support are less than 10% plus 53% of the amount subject to withholding, the Department will deduct the entire \$13.50 for income tax withholding (~~\$128~~ for State of Illinois income tax withholding (\$6 in each week) and the remaining ~~\$1.50~~5.50 for federal income tax withholding (\$.75 in each week) and not pay the individual any benefits for this period.

- c) An individual's election and his revocation of his election to have monies withheld from his benefits for possible federal and/or State of Illinois income tax liability shall be prospective only. Any decision made by the Department as to whether an individual has, under the Act, elected withholding or revoked a withholding election shall constitute a final administrative decision, subject to review under the Administrative Review Law [735 ILCS 5/Art. III].

EXAMPLE: Upon filing an additional claim during his benefit year, an individual elects to have federal and State of Illinois income tax withheld from his unemployment benefits paid in 2006. His first benefit check covers the two-week period beginning January 8, 2006 and ending January 21, 2006. His WBA is \$250, and the amount subject to withholding for the period is \$65 (10% and 3% of \$500). For each week, he is subject to recoupment of 25% of his WBA and a withholding order of \$100 for child

## DEPARTMENT OF EMPLOYMENT SECURITY

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support. Consequently, his benefit check for the two-week period is for \$110. When he receives his benefit check, he asks to revoke the elections, explaining he thought the income tax withholding would be based on a percentage of his WBA after recoupment and child support. While the Department, if he desires, will revoke his elections to withhold with respect to a period that has not yet ended, it will not retroactively revoke his elections with respect to January 8 through January 21. Elections and revocations can only operate prospectively.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 2801, effective January 30, 2011, for a maximum of 150 days)

## ILLINOIS RACING BOARD

## NOTICE OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Medication
- 2) Code Citation: 11 Ill. Adm. Code 603
- 3) 

<u>Section Numbers:</u>	<u>Emergency Action:</u>
603.70	Amendment
603.90	Amendment
603.210	Amendment
- 4) Statutory Authority: 230 ILCS 5/9(b)
- 5) Effective Date of Emergency Amendments: January 26, 2011
- 6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which they are to expire: The emergency rulemaking will expire at the end of the 150-day period, or upon adoption of permanent rules, whichever comes first.
- 7) Date filed with the Index Department: January 26, 2011
- 8) A copy of the emergency amendments, including any material incorporated by reference, is on file in the Illinois Racing Board's central office and is available for public inspection.
- 9) Reason for Emergency: Expand the Board's Medication rule governing anabolic steroids to include threshold levels in plasma. The Thoroughbred Owners and Breeders Association (TOBA) is responsible for grading all thoroughbred stakes races. The grading system assigns a grade (1, 2 or 3) to a stakes race based on the relative quality of the race. TOBA requires that to maintain a graded status, extensive drug testing must be performed on the racehorses participating, including the testing for anabolic steroids in plasma. There are two graded stakes in early April at Hawthorne Race Course and the proposed rulemaking needs to be put in place prior to April 1, 2011. Failure to implement TOBA's drug testing requirement may jeopardize the graded status of Hawthorne's two stakes races.
- 10) A Complete Description of the Subjects and Issues Involved: This rulemaking expands the Board's Medication rule governing anabolic steroids in racehorses, Section 603.210, to include plasma threshold levels for four anabolic steroids. Currently, only threshold levels in urine for four anabolic steroids are permitted. The proposed rulemaking also

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corrects typographical errors to Section 603.70(b)(1)(2). The proposed amendment to Section 603.90 adds written approval from the "Executive Director or his designee" and expands the list of prohibited substances to include Bee Venom.

- 11) Are there any proposed amendments pending on this Part: Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Register Citation:</u>
603.60	Amendment	35 Ill. Reg. 185; January 3, 2011
603.75	Amendment	35 Ill. Reg. 185; January 3, 2011
603.160	Amendment	35 Ill. Reg. 185; January 3, 2011

- 12) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.

- 13) Information and questions regarding this emergency rulemaking shall be directed to:

Mickey Ezzo  
Illinois Racing Board  
100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601

312/814-5017

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

## ILLINOIS RACING BOARD

## NOTICE OF EMERGENCY AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
SUBTITLE B: HORSE RACING  
CHAPTER I: ILLINOIS RACING BOARD  
SUBCHAPTER c: RULES APPLICABLE TO ALL OCCUPATION LICENSEES

PART 603  
MEDICATION

## Section

- 603.10 Pre-Race Saliva Tests
- 603.20 Racing Soundness Exam
- 603.30 Foreign Substances and Pharmaceutical Aids Banned
- 603.40 Twenty-four Hour Ban
- 603.50 Trainer Responsibility
- 603.55 Prima Facie Evidence
- 603.60 Permitted Use of Foreign Substances and Threshold Levels
- 603.70 Furosemide

EMERGENCY

- 603.75 Environmental Contaminants
- 603.80 Needles, Syringes and Injectables
- 603.90 Drugs, Chemicals and Prescription Items

EMERGENCY

- 603.100 Detention Barn
- 603.110 Test Samples
- 603.120 Referee Samples
- 603.130 Laboratory Findings and Reports
- 603.140 Distribution of Purses
- 603.150 Post Mortems
- 603.160 Penalties
- 603.170 Veterinarian's Records
- 603.180 Carbon Dioxide Tests
- 603.190 Erythropoietin and Darbepoietin Antibody Testing Program
- 603.200 Out of Competition Testing
- 603.210 Androgenic-Anabolic Steroids (AAS)

EMERGENCY

AUTHORITY: Implementing and authorized by Section 9(b) of the Illinois Horse Racing Act of 1975 [230 ILCS 5/9(b)].

## ILLINOIS RACING BOARD

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SOURCE: Adopted at 21 Ill. Reg. 3232, effective March 4, 1997; amended at 22 Ill. Reg. 2217, effective January 1, 1998; amended at 22 Ill. Reg. 3594, effective February 1, 1998; amended at 25 Ill. Reg. 15611, effective December 1, 2001; amended at 26 Ill. Reg. 12360, effective August 1, 2002; amended at 27 Ill. Reg. 5027, effective March 7, 2003; amended at 27 Ill. Reg. 7331, effective April 15, 2003; amended at 28 Ill. Reg. 1374, effective January 19, 2004; amended at 28 Ill. Reg. 4751, effective March 1, 2004; emergency amendment at 28 Ill. Reg. 7565, effective May 11, 2004, for a maximum of 150 days; emergency expired October 7, 2004; amended at 28 Ill. Reg. 11250, effective August 1, 2004; amended at 28 Ill. Reg. 15790, effective December 1, 2004; emergency amendment at 29 Ill. Reg. 2779, effective February 22, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 4116, effective February 25, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5726, effective April 8, 2005; amended at 29 Ill. Reg. 12265, effective July 24, 2005; amended at 29 Ill. Reg. 14038, effective September 1, 2005; emergency amendment at 30 Ill. Reg. 14371, effective August 21, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18729, effective November 20, 2006; amended at 31 Ill. Reg. 1478, effective January 1, 2007; emergency amendment at 31 Ill. Reg. 6680, effective April 23, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 12982, effective September 1, 2007; amended at 32 Ill. Reg. 7397, effective May 1, 2008; amended at 33 Ill. Reg. 12571, effective August 25, 2009; expedited correction at 34 Ill. Reg. 9551, effective August 25, 2009; emergency amendment at 35 Ill. Reg. 2810, effective January 26, 2011, for a maximum of 150 days.

**Section 603.70 Furosemide****EMERGENCY**

- a) The Board recognizes that Exercise Induced Pulmonary Hemorrhage (EIPH) is almost universal in performance horses. The Board also recognizes that the diuretic furosemide is helpful in the management of the EIPH syndrome, this includes horses that already had a bleeding episode as well as horses that have not yet exhibited the epistaxis. In regulating the race day use of furosemide, the Board has placed strict controls on the dose, route and time the medication is administered. Additionally, Board security personnel monitors these horses during and after the administration. Advances in drug testing techniques permit the Board laboratory to quantitate post-race serum samples for furosemide, providing a thorough regulation of the drug. All of these measures are designed to prevent the misuse of furosemide.
  
- b) Eligibility for Furosemide Treatment  
A horse is eligible to race with furosemide if at least one of the following occurs:

## ILLINOIS RACING BOARD

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- 1) The horse is on the Illinois Furosemide List and has complied with subsection (cd);
  - 2) The horse is on the Illinois Bleeder List and has complied with subsection (de);
  - 3) The trainer provides the State Veterinarian or his or her designee with evidence that the horse is on the Furosemide List or Bleeder List in another racing jurisdiction. Acceptable evidence shall be a furosemide or bleeder certificate approved by an official veterinarian. The certification date shall be the date shown on the furosemide or bleeder certificate;
  - 4) The trainer provides the State Veterinarian or his or her designee with evidence that the horse has been running consistently, up to its last start, with furosemide in other racing jurisdictions as shown on the official past performance lines. Acceptable past performance lines for thoroughbreds and/or quarter horses shall be Equibase and/or Racing Form. Acceptable past performance lines for standardbreds shall be the official past performances of the United States Trotting Association (USTA) or Canadian Trotting Association (CTA) or the eligibility papers. The certification date shall be the earliest available date the horse shows running with furosemide on the official past performance lines. If the past performance lines of a horse show that the horse has been running on and off furosemide in other racing jurisdictions, the horse shall not be permitted to run with furosemide in Illinois, unless the occasions the horse ran without furosemide were due to rule restrictions imposed on the horse by those particular racing jurisdictions.
- c) Furosemide List  
Furosemide shall be administered to a horse that is entered to race only after the State Veterinarian has placed the horse on the Furosemide List. In order for a horse to be placed on the Furosemide List, the following process shall be followed:
- 1) After the horse's licensed trainer and licensed veterinarian determine that it would be in the horse's best interests to race with furosemide, they shall notify the State Veterinarian or his or her designee, using the prescribed form provided by the Board, that they wish the horse to be placed on the Furosemide List.

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- 2) The form must be received by the State Veterinarian or his or her designee no later than the time of entry to ensure public notification prior to race participation.
  - 3) A horse placed on the Furosemide List must remain on that list until the licensed trainer and licensed veterinarian submit a written request to remove the horse from the list. The request must be made to the State Veterinarian or his or her designee, on the proper form, no later than the time of entry.
  - 4) After a horse has been removed from the Furosemide List, the horse may not be placed back on the list for a period of 60 calendar days unless it is determined, in consultation with the State Veterinarian, to be detrimental to the welfare of the horse. If a horse is removed from the Furosemide List a second time in a 365-day period, the horse may not be placed back on the list for a period of 90 calendar days.
- d) Bleeder List
- 1) The State Veterinarian shall maintain a Bleeder List of all horses that have demonstrated:
    - A) External evidences of exercise induced pulmonary hemorrhage from one or both nostrils during or after a race or workout, as observed by an official veterinarian.
    - B) Internal evidences of exercise induced pulmonary hemorrhage via endoscopy reported by a licensed practicing veterinarian on a Board approved form.
  - 2) Every confirmed bleeder, regardless of age, shall be placed on the Bleeder List and be ineligible to race for the following time periods:
    - A) First incident – 14 days;
    - B) Second incident within a 365 day period – 30 days;
    - C) Third incident within a 365 day period – 180 days;

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- D) Fourth incident within a 365 day period – Barred from racing for its lifetime.
  - 3) For the purposes of counting the number of days a horse is ineligible to run, the day the horse bled is the first day of the recovery period.
  - 4) After the expiration of the barred periods in subsections (d)(2)(A), (B) and (C), a horse must perform a workout, without bleeding, to the satisfaction of the State Veterinarian. Prior to the workout, a blood sample may be collected by the State Veterinarian and sent to the Board laboratory for testing. After the workout, the State Veterinarian may witness an endoscopic examination of the horse to confirm that it has not bled.
  - 5) All horses on the Bleeder List that are eligible to race shall be administered furosemide pursuant to subsection (f).
- e) Furosemide Administration
- 1) All horses on the Furosemide List must be treated with furosemide in order to be permitted to participate in a race.
  - 2) Furosemide shall be administered between 4 hours and 15 minutes and 3 hours and 45 minutes prior to the scheduled post time of the race in which a horse is entered.
  - 3) A Board licensed veterinarian shall administer not less than 150 mg and not more than 500 mg of furosemide by single intravenous injection and shall verify the administration on Board prescribed affidavits no later than one hour prior to the post time for the race for which the horse is entered.
  - 4) The trainer or his or her licensed employee shall witness the furosemide administration.
  - 5) The administration of furosemide may take place in the horse's own stall or in a centralized location.
  - 6) Failure to administer furosemide in accordance with subsection (e)(2) may result in the horse being scratched from the race by the Stewards and the

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trainer may be fined not less than \$200 and not more than \$500.

- f) Removal from Bleeder List
  - 1) Once a horse is placed on the Bleeder List, it must continue to race with furosemide unless the removal from the list is approved by the State Veterinarian. The State Veterinarian may remove a horse from the Bleeder List upon written request of the trainer, if the horse's performance is negatively affected by the use of furosemide or if the horse has an adverse physiological reaction to furosemide.
  - 2) Once removed from the Bleeder List, a thoroughbred horse shall be ineligible to participate in a race for a minimum of 30 days. A standardbred horse shall be ineligible for a minimum of 14 days. The ineligibility period shall be counted from the day the State Veterinarian approves the removal of the horse from the Bleeder List. Prior to starting in a race, a horse must participate without furosemide in a qualifying race or perform an official workout without bleeding, to the satisfaction of the State Veterinarian. Prior to the qualifying race or workout, a blood sample may be collected by the State Veterinarian and sent to the Board laboratory for testing. After the qualifying race or workout, the State Veterinarian may witness an endoscopic examination of the horse to confirm that it has not bled.
- g) Absence of Furosemide

In the event a horse listed on the furosemide list races without furosemide, the horse shall be disqualified and any purse money earned by the horse redistributed. In addition, the stewards may suspend or fine the trainer and/or veterinarian not less than \$200 and not more than \$1500.
- h) Excessive Use of Furosemide
  - 1) The test level for furosemide shall not be in excess of 100 nanograms (ng) per milliliter (ml) of serum or plasma.
  - 2) The first time the laboratory reports an amount of furosemide in excess of 100 nanograms, the trainer shall be fined \$250.
  - 3) The second time the laboratory reports an amount of furosemide in excess

## ILLINOIS RACING BOARD

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of 100 nanograms within 365 days after the first offense, the trainer shall be fined \$500.

- 4) For a third or subsequent laboratory report of an amount of furosemide in excess of 100 nanograms within 365 days after the first offense, the trainer shall be fined \$1,000 and/or suspended for 15 days and the purse shall be redistributed.
- 5) When imposing penalties, the stewards shall consider the criteria in Section 603.160(b)(3), (4), (5) and (6) of this Part.
  - i) Trainer's Responsibilities for Horses on the Furosemide List
    - 1) The trainer shall be responsible for:
      - A) providing the racing office at the time of entry with accurate information regarding the use of furosemide on horses he/she enters to race;
      - B) providing the information required for furosemide approval of his/her horses to Board staff coordinating the administration of furosemide;
      - C) notifying his/her veterinarian of furosemide horses and the date and times for race day treatment;
      - D) having horses on the furosemide list stabled at the barn and in the stall assigned by the Racing Secretary or his/her designee;
      - E) posting a "Security Stall" sign on the stalls of his/her horses entered to race (see 11 Ill. Adm. Code 436);
      - F) ensuring horses are treated with furosemide on race day at the prescribed time, witnessing the administration of furosemide and guarding the horse until the horse is taken to the paddock (see 11 Ill. Adm. Code 436).
    - 2) The stewards may suspend the trainer or assess a fine of no less than \$200 and no more than \$500 for violation of this subsection (i).

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- j) Veterinarian's Responsibilities
  - 1) The practicing veterinarian shall be responsible for:
    - A) administering the proper furosemide medication and dose at the proper time to the proper horse.
    - B) providing Board staff, upon request, with any documentation related to horses that are stabled on approved facilities and medication samples and/or paraphernalia used to administer any medication to a horse. Samples and/or paraphernalia may be sent to the Board laboratory for testing.
  - 2) The stewards may suspend the veterinarian or assess a fine of no less than \$200 and no more than \$500 for violations of this subsection (j).
- k) Security
  - 1) Each horse racing with furosemide shall be detained in a stall assigned by the Racing Secretary at least 4 hours and 15 minutes before the post time of the race in which it is entered, and shall remain in the stall until taken to the paddock to be saddled or harnessed for the race, except that the stewards may permit horses to leave the "security stall" to engage in exercise blow-outs or warm-up heats.
  - 2) The barn area is a secure area and shall be under the supervision of the Board.
  - 3) No unauthorized person shall approach the security area. If any unauthorized person does approach the security area, a report of the incident is to be made immediately to one of the State Veterinarians, the stewards or a Board investigator.
  - 4) Board staff may direct a veterinarian to take a blood sample immediately prior to the administration of furosemide to be submitted to the Board's laboratory for analysis.
  - 5) Board staff may collect from a veterinarian the syringe containing any

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medication about to be administered to a horse for testing at the Board laboratory.

- l) This Section shall apply to all horses entering in and competing in race meetings as defined in Section 3.07 of the Act [230 ILCS 5/3.07], as well as all horses shipping in from other racing jurisdictions, domestic or foreign.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 2810, effective January 26, 2011, for a maximum of 150 days)

**Section 603.90 Drugs, Chemicals and Prescription Items****EMERGENCY**

- a) No veterinarian or any other person shall have in his or her possession or administer to any horse within any race track enclosure any chemical substance that:
  - 1) has not been approved for use on equines by the Food and Drug Administration, pursuant to the Federal Food, Drug and Cosmetic Act (21 USC 301 et seq.) and implementing regulations, without prior written approval from the State [Veterinarian and Executive Director or his or her designeeveterinarian](#);
  - 2) is on any of the schedules of controlled substances prepared by the Attorney General of the United States pursuant to 21 USC 811 and 812, without prior written approval from the State Veterinarian [and Executive Director or his or her designee](#); or
  - 3) the possession and/or use, on the premises of a facility under the jurisdiction of the Board, of any drug, substance or medication specified in this subsection (a)(3) for which a recognized analytical method has not been developed to detect and confirm its administration, or the use of which may endanger the health and welfare of the horse or the safety of the rider or driver.
    - A) Erythropoietin (EPO)
    - B) Darbepoietin

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- C) Snake venom
  - D) Snail venom
  - E) [Bee Venom](#)
- b) The State Veterinarian [and Executive Director or his or her designee](#), shall not give approval under subsection (a) unless the person seeking approval can produce evidence in recognized veterinary journals or by recognized equine experts that the chemical substance has a beneficial, therapeutic use in horses.
  - c) No person except a veterinarian shall have in his or her possession within a race track enclosure any prescription drug, except as provided in this Section.
  - d) A person may possess a prescription drug for animal use if:
    - 1) The person possesses, within the race track enclosure, documentary evidence that a prescription has been issued for the prescription drug;
    - 2) The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug; and
    - 3) The horse or horses named in the prescription are in that person's care within the race track enclosure.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 2810, effective January 26, 2011, for a maximum of 150 days)

**Section 603.210 [Androgenic-Anabolic Steroids \(AAS\)](#)  
[EMERGENCY](#)**

- a) [No AAS shall be permitted in test samples collected from racing horses except for residues of the major metabolite of stanozolol, nandrolone, and the naturally occurring substances boldenone and testosterone at concentrations less than the indicated thresholds.](#)
- b) [Concentrations of these AAS shall not exceed the following threshold concentrations for total \(i.e., free drug or metabolite and drug or metabolite liberated from its conjugates\) drug:](#)

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1) In urine:

- A)  $16\beta$ -hydroxystanozolol (metabolite of stanozolol (Winstrol)) – 1 ng/ml in urine for all horses regardless of sex.
- B) Boldenone (Equipoise® is the undecylenate ester of boldenone) in male horses other than geldings – 15 ng/ml in urine. No boldenone shall be permitted in geldings or female horses.
- C) Nandrolone (Durabolin® is the phenylpropionate ester and Deca-Durabolin® is the decanoate ester) –
- i) In geldings – 1 ng/ml in urine.
- ii) In fillies and mares – 1 ng/ml in urine.
- iii) In male horses other than geldings – 45 ng/ml of metabolite,  $5\alpha$ -oestrane- $3\beta,17\alpha$ -diol in urine.
- D) Testosterone –
- i) In geldings – 20 ng/ml in urine.
- ii) In fillies and mares – 55 ng/ml.
- iii) Male horses other than geldings will not be tested.

2) In plasma:

- A) Stanozolol – screening limit no greater than 100 pg/ml in serum or plasma with a confirmatory threshold no greater than 25 pg/ml for all horses regardless of sex.
- B) Boldenone – screening limit no greater than 100 pg/ml in serum or plasma with a confirmatory threshold no greater than 25 pg/ml for all horses regardless of sex.

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- C) Nandrolone – screening limit no greater than 100 pg/ml in serum or plasma with a confirmatory threshold no greater than 25 pg/ml for geldings and fillies and mares. Male horses other than geldings will not be tested.
- D) Testosterone –
- i) In geldings – screening limit no greater than 100 pg/ml in serum or plasma with a confirmatory threshold no greater than 25 pg/ml.
- ii) In fillies and mares – screening limit no greater than 100 pg/ml in serum or plasma with a confirmatory threshold no greater than 25 pg/ml.
- iii) In male horses other than geldings – confirmatory threshold no greater than 2,000 pg/ml.
- c) All other AAS are prohibited in racing horses.
- d) Post-race urine and blood samples collected from intact males must be identified to the laboratory.
- e) Any horse to which an anabolic steroid has been administered in order to assist in the recovery from illness or injury may be placed on the veterinarian's list in order to monitor the concentration of the drug or metabolite in urine. After the concentration has fallen below the designated threshold for the administered AAS, the horse is eligible to be removed from the list.
- ~~a) The use of any one of the following four anabolic steroids is permitted if the following urine or plasma threshold concentrations are not exceeded:~~
- ~~1) Stanozolol (Winstrol) – 1 ng/ml in urine;~~
  - ~~2) Boldenone (Equipose) – in male horses other than geldings; including free boldenone and boldenone liberated from its conjugates – 15 ng/ml in urine;~~
  - ~~3) Nandrolone – 1 ng/ml in urine; and~~

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- 4) ~~Testosterone—20 ng/ml in urine in geldings and 55 ng/ml in urine in fillies and mares.~~
- b) ~~No other anabolic steroids shall be administered.~~
- e) ~~The presence of more than one of the four approved anabolic steroids at any concentration is not permitted.~~
- d) ~~Post race urine samples collected from intact males shall be identified to the laboratory.~~
- e) ~~Any horse to which an anabolic steroid has been administered in order to assist in the recovery from an illness or injury may be placed on the State Veterinarian's list in order to monitor the concentration of the drug in urine. Once the concentration is below the designated threshold, the horse is eligible to be removed from the State Veterinarian's list.~~

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 2810, effective January 26, 2011, for a maximum of 150 days)

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 January 25, 2011 through January 31, 2011 and have been scheduled for review by the Committee at its March 8, 2011 meeting. 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.

<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start Of First Notice</u>	<u>JCAR Meeting</u>
3/10/11	<u>Department of Insurance</u> , Unearned Premium Reserve Computation (Repealer) (50 Ill. Adm. Code 911)	8/27/10 34 Ill. Reg. 12301	3/8/11
3/10/11	<u>Department of Insurance</u> , Life Reinsurance Agreements (50 Ill. Adm. Code 1103)	8/27/10 34 Ill. Reg. 12304	3/8/11
3/10/11	<u>Department of Human Services</u> , General Administrative Provisions (89 Ill. Adm. Code 10)	9/24/10 34 Ill. Reg. 13579	3/8/11
3/10/11	<u>Department of Human Services</u> , Supplemental Nutrition Assistance Program (SNAP) (89 Ill. Adm. Code 121)	9/24/10 34 Ill. Reg. 13597	3/8/11
3/10/11	<u>Department of Financial and Professional Regulation</u> , Real Estate License Act of 2000 (Repealer) (68 Ill. Adm. Code 1450)	10/22/10 34 Ill. Reg. 15949	3/8/11
3/10/11	<u>Department of Financial and Professional Regulation</u> , Real Estate License Act of 2000 (68 Ill. Adm. Code 1450)	10/22/10 34 Ill. Reg. 16062	3/8/11
3/11/11	<u>Office of the Auditor General</u> , Purchases and Contracts (44 Ill. Adm. Code 500)	11/29/10 34 Ill. Reg. 18010	3/8/11

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

## SECOND NOTICES RECEIVED

3/11/11	<u>Secretary of State, Illinois State Library Grant Programs (23 Ill. Adm. Code 3035)</u>	12/3/10 34 Ill. Reg. 18954	3/8/11
3/11/11	<u>Illinois Commerce Commission, Rules of Practice (83 Ill. Adm. Code 200)</u>	4/9/10 34 Ill. Reg. 4947	3/8/11
3/11/11	<u>Illinois Commerce Commission, Standards of Service for Local Exchange Telecommunications Carriers (83 Ill. Adm. Code 730)</u>	5/28/10 34 Ill. Reg. 7360	3/8/11
3/11/11	<u>Illinois Commerce Commission, Customer Credits (83 Ill. Adm. Code 732)</u>	4/9/10 34 Ill. Reg. 4954	3/8/11
3/11/11	<u>Office of the State Fire Marshal, Illinois Elevator Safety Rules (41 Ill. Adm. Code 1000)</u>	7/9/10 34 Ill. Reg. 8872	3/8/11
3/16/11	<u>Department of Public Health, Hospital Licensing Requirements (77 Ill. Adm. Code 250)</u>	10/8/10 34 Ill. Reg. 15127	3/8/11

## DEPARTMENT OF REVENUE

## NOTICE OF PUBLIC INFORMATION

Pursuant to the provisions of 20 ILCS 1605/7.1, the Illinois Department of Revenue, Lottery Division, shall publish each January in the Illinois Register a list of all game-specific rules, play instructions, directives, operations manuals, brochures, or other game-specific publications issued by the Division during the previous year. Following is the list of game-specific materials published by the Lottery during calendar year 2010.

## Standard Instant Game Rules

Powerball/Mega Millions Instant Game IL-727 Rules

Cash 4 College Instant Game IL-729 Rules

On-Line Game Rules

Mega Millions Game Rules

Millionaire Raffle Game Rules effective February 18, 2010 – March 17, 2010

Millionaire Raffle Game Rules effective October 1, 2010 – October 31, 2010

Live Like a Chicago Bull for a Day Promotion Official Rules &amp; Procedures (2010)

Chicago Blackhawks® Cash Second Chance Promotion Official Rules and Procedures (2009-10)

Chicago Blackhawks® Cash Air-Hockey® Tournament Series Official Rules (2010)

The Wedding of Your Dreams Promotion Official Rules and Procedures

Ticket for the Cure Turn up the Pink Promotion Official Rules

Ticket for the Cure Turn up the Pink Bouquet Promotion Official Rules

Illinois Lottery Second Chance Lake House Living Getaway Official Contest Rules

Summer Event Procedures 2010

Veterans Cash Proud to Give Decoder Promotion Official Rules

Green Ball Double Draw Promotion Official Rules and Procedures (December 2010)

Chicago Blackhawks® Second Chance Promotion Official Rules &amp; Procedures (2010-11)

Chicago Blackhawks® Second Chance Promotion Entry Instructions

Live Like a Chicago Bull for a Day Promotion Official Rules &amp; Procedures (2011)

Live Like a Chicago Bull for a Day Promotion Entry Instructions

Red Ribbon Cash Wrap it Up Illinois, Show Your Support Promotion Rules (2010-11)

Mega Millions, Lotto and Little Lotto Subscription flyer

Mega Millions Megaplier flyer

Instant Game Prize List

2010 Winning Numbers Lists (Pick 3, Pick 4, Little Lotto, Lotto, Mega Millions, Millionaire Raffle)

2010 Winning Numbers in Order Drawn (Little Lotto, Lotto, Mega Millions)

Lottery Financial History, Sales by Game/Where Your Dollar Goes

"Victory Dances" Guide to Playing the Illinois Lottery (Mega Millions, Lotto, Little Lotto, Pick 3/4 and Instants)

Chances of Winning Lotto, Little Lotto or Mega Millions

Mega Millions, Lotto and Little Lotto Subscription Forms

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

Record North American Jackpots  
Top Big Game/Mega Millions Jackpots  
Top Lotto Jackpots  
Top Illinois Jackpots  
Retailer Newsletter

Copies of the foregoing may be obtained by submitting a written request to:

Freedom of Information Officer  
Illinois Department of Revenue  
101 West Jefferson, MC 6-595  
Springfield, Illinois 62702

**ILLINOIS ADMINISTRATIVE CODE**  
**Issue Index - With Effective Dates**

Rules acted upon in Volume 35, Issue 7 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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