2014

ILLINOIS

REGISTER

Rules of
Governmental Agencies

Volume 38, Issue 8

February 21, 2014

Pages 4549-5440

Index Department
Administrative Code Division
111 E. Monroe St.
Springfield, IL 62756
217-782-7017

Printed by authority of the State of Illinois. February — 90

PUBLISHED BY JESSE WHITE • SECRETARY OF STATE

TABLE OF CONTENTS

February 21, 2014 Volume 38, Issue 8

PROPOSED RULES

AGRICULTURE, DEPARTMENT OF
Forever Green Illinois Program
8 Ill. Adm. Code 241.....4549
ENVIRONMENTAL PROTECTION AGENCY, ILLINOIS
Permits
35 Ill. Adm. Code 652.....4554
HEALTHCARE AND FAMILY SERVICES, DEPARTMENT OF
Medical Payment
89 Ill. Adm. Code 140.....4559
Specialized Health Care Delivery Systems
89 Ill. Adm. Code 146.....4628
Hospital Services
89 Ill. Adm. Code 148.....4640
Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
89 Ill. Adm. Code 149.....4932
Hospital Reimbursement Changes
89 Ill. Adm. Code 152.....4977
INSURANCE, DEPARTMENT OF
Improper Claims Practice
50 Ill. Adm. Code 919.....4999
NATURAL RESOURCES, DEPARTMENT OF
The Coal Mining Act
62 Ill. Adm. Code 140.....5010
POLLUTION CONTROL BOARD
Hazardous Waste Management System: General
35 Ill. Adm. Code 720.....5016
Identification and Listing of Hazardous Waste
35 Ill. Adm. Code 721.....5077
PUBLIC HEALTH, DEPARTMENT OF
Newborn Metabolic Screening and Treatment Code
77 Ill. Adm. Code 661.....5142
REVENUE, DEPARTMENT OF
Income Tax
86 Ill. Adm. Code 100.....5148
SECRETARY OF STATE
Issuance of Licenses
92 Ill. Adm. Code 1030.....5163
Commercial Driver Training Schools
92 Ill. Adm. Code 1060.....5214

Online Only Adult Driver Education Course Provider Certification
92 Ill. Adm. Code 1066.....5228
ADOPTED RULES
CENTRAL MANAGEMENT SERVICES, DEPARTMENT OF
Pay Plan
80 Ill. Adm. Code 310.....5250
HUMAN SERVICES, DEPARTMENT OF
General Administrative Provisions
89 Ill. Adm. Code 10.....5375
Supplemental Nutrition Assistance Program (SNAP)
89 Ill. Adm. Code 121.....5382
NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS
SECRETARY OF STATE
Lobbyist Registration and Reports
2 Ill. Adm. Code 560.....5395
NOTICE OF CODIFICATION CHANGES
PUBLIC HEALTH, DEPARTMENT OF
Control of Communicable Diseases Code
77 Ill. Adm. Code 690.....5408
SECOND NOTICES RECEIVED
JOINT COMMITTEE ON ADMINISTRATIVE RULES
Second Notices Received.....5410
EXECUTIVE ORDERS AND PROCLAMATIONS
PROCLAMATIONS
Chicago Music Awards Day
2014-23.....5411
Martin Luther King, Jr. Day of Service
2014-24.....5411
Perianesthesia Nurse Awareness Week
2014-25.....5413
Epilepsy Awareness Month
2014-26.....5414
Motorcycle Awareness Month
2014-27.....5415
Illinois Nurse Anesthetists Week
2014-28.....5415
Anti-Cruelty Society Day
2014-29.....5416
Arts in Education Spring Celebration Months
2014-30.....5417
FFA Week
2014-31.....5418
Fred Korematsu Day
2014-32.....5419

Women in Construction Week
2014-33.....5420
Illinois Electric and Telephone Cooperatives Youth Day
2014-34.....5421
Men's Health Week
2014-35.....5422
Charleston Riot Days
2014-36.....5423
National Trio Day
2014-37.....5424
Save Abandoned Babies Month
2014-38.....5425
Early Hearing Detection and Intervention Day
2014-39.....5425
Ice Safety Awareness Month
2014-40.....5426
Illinois Poison Prevention Month
2014-41.....5428
Preeclampsia Awareness Day
2014-42.....5428
The Band Chicago Day
2014-43.....5429
Youth Art Month
2014-44.....5431
Illinois Arts Education Week
2014-45.....5431
DeMolay Month
2014-46.....5432
Rethink Your Drink Month
2014-47.....5433
Saint Mark's Protestant Episcopal Church Day
2014-48.....5434
Court Reporting and Captioning Week
2014-49.....5435
Ependymoma Awareness Day
2014-50.....5436
Illinois Flag Display Act Vincent Petrella
2014-51.....5437
National Black HIV/AIDS Awareness Day
2014-52.....5438
Fair Housing Month
2014-53.....5439

INTRODUCTION

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

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

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

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

ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2014

Issue#	Rules Due Date	Date of Issue
1	December 23, 2013	January 3, 2014
2	December 30, 2013	January 10, 2013
3	January 6, 2014	January 17, 2014
4	January 13, 2014	January 24, 2014
5	January 21, 2014	January 31, 2014
6	January 27, 2014	February 7, 2014
7	February 3, 2014	February 14, 2014
8	February 10, 2014	February 21, 2014
9	February 18, 2014	February 28, 2014
10	February 24, 2014	March 7, 2014
11	March 3, 2014	March 14, 2014
12	March 10, 2014	March 21, 2014
13	March 17, 2014	March 28, 2014
14	March 24, 2014	April 4, 2014
15	March 31, 2014	April 11, 2014
16	April 7, 2014	April 18, 2014
17	April 14, 2014	April 25, 2014
18	April 21, 2014	May 2, 2014

19	April 28, 2014	May 9, 2014
20	May 5, 2014	May 16, 2014
21	May 12, 2014	May 23, 2014
22	May 19, 2014	May 30, 2014
23	May 27, 2014	June 6, 2014
24	June 2, 2014	June 13, 2014
25	June 9, 2014	June 20, 2014
26	June 16, 2014	June 27, 2014
27	June 23, 2014	July 7, 2014
28	June 30, 2014	July 11, 2014
29	July 7, 2014	July 18, 2014
30	July 14, 2014	July 25, 2014
31	July 21, 2014	August 1, 2014
32	July 28, 2014	August 8, 2014
33	August 4, 2014	August 15, 2014
34	August 11, 2014	August 22, 2014
35	August 18, 2014	August 29, 2014
36	August 25, 2014	September 5, 2014
37	September 2, 2014	September 12, 2014
38	September 8, 2014	September 19, 2014
39	September 15, 2014	September 26, 2014
40	September 22, 2014	October 3, 2014
41	September 29, 2014	October 10, 2014
42	October 6, 2014	October 17, 2014
43	October 14, 2014	October 24, 2014
44	October 20, 2014	October 31, 2014
45	October 27, 2014	November 7, 2014
46	November 3, 2014	November 14, 2014
47	November 10, 2014	November 21, 2014
48	November 17, 2014	December 1, 2014
49	November 24, 2014	December 5, 2014
50	December 1, 2014	December 12, 2014
51	December 8, 2014	December 19, 2014
52	December 15, 2014	December 26, 2014

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED RULES

1) Heading of the Part: Forever Green Illinois Program

2) Code Citation: 8 Ill. Adm. Code 241

3)

Section Numbers:	Proposed Action:
241.10	New
241.20	New
241.30	New
241.40	New
241.50	New
241.60	New

4) Statutory Authority: Section 205-103 of the Civil Administrative Code of Illinois [20 ILCS 205/205-103]

5) A Complete Description of the Subjects and Issues Involved: Section 205-103 of the Civil Administrative Code of Illinois (20 ILCS 205/205-103) creates within the Illinois Department of Agriculture the Forever Green Illinois Program. The program is to be administered by the Department of Agriculture as provided in the Code and this Part. The program is established to maintain and beautify greenery on property owned or controlled by the State or a unit of local government. The program will consist of a series of pilot projects wherein the Department will execute cooperative agreements with a limited number of municipalities to remove a specified number of trees negatively impacting public and/or private property infrastructure and replant with more appropriate trees and/or shrubs.

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

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

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

9) Does this rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: This rulemaking does not adversely affect units of local government. Local governments may benefit from the tree removal and replanting services provided under the program.

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED RULES

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: A 45-day written comment period will begin on the day the Notice of Proposed Amendment appears in the *Illinois Register*. Please mail written comments on the proposed rulemaking to the attention of:

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

217/524-6905
217/785-4505 (fax)

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Tree-care companies, local arborists, tree and shrub nurseries, and a limited number of small villages or municipalities could be affected should they become local cooperators in the program. Since the program is voluntary, there should be no adverse impact.

B) Reporting, bookkeeping or other procedures required for compliance: Program is voluntary and any reporting, bookkeeping or other procedures would not be excessive beyond those typically associated with an intergovernmental agreement or a service contract.

C) Types of professional skills necessary for compliance: Program is voluntary and the only professional skills required with participation would be those associated with tree removal and/or tree and shrub planting.

14) Regulatory agenda on which this rulemaking was summarized: January 2014

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

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED RULES

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER h: PESTS AND PLANT DISEASES

PART 241
FOREVER GREEN ILLINOIS PROGRAM

Section
241.10 Definitions
241.20 General Provisions and Purpose
241.30 Eligibility
241.40 Priority to Existing Tree City USA Communities
241.50 Government Record of Problem Trees
241.60 Tree Removal and Greenery Placement

AUTHORITY: Implementing and authorized by Section 205-103 of the Civil Administrative Code of Illinois [20 ILCS 205/205-103]

SOURCE: Adopted at 38 Ill. Reg. _____, effective _____.

Section 241.10 Definitions

"Participating Entity" means a State agency or unit of local government that has been selected by the Department as a participant of the Forever Green Illinois Program.

"Problem Trees" means trees located on property owned or controlled by the State or a unit of local government in a pilot project area that are currently damaging public or private infrastructure; are of ill health and are presently or may soon pose a threat to public safety; or are currently infested with an invasive insect pest or plant disease such as, but not limited to, the Emerald Ash Borer.

"Greenery" means grass, weeds, trees, shrubs, bushes, plants and other plant material.

Section 241.20 General Provisions and Purpose

Section 205-103 of the Civil Administrative Code of Illinois [20 ILCS 205/205-103] creates within the Department the Forever Green Illinois Program, to be administered by the Department as provided in the Code and this Part. The program is established to maintain and beautify

greenery on property owned or controlled by the State or a unit of local government. The goals of the program are to:

a) Assist participating entities in dealing with negative impacts on community and private infrastructure from improperly maintained trees on public rights of way;

b) Assist participating entities in dealing with the aftermath of devastating invasive insect pests and plant disease infestations, including, but not limited to, the Emerald Ash Borer; and

c) Promote adoption of tree planting and maintenance programs for trees and other greenery intended to avoid future infrastructure damage from those plantings.

Section 241.30 Eligibility

a) Participation in the Forever Green Illinois Program is limited to State agencies and units of local government for the maintenance and beautification of property owned or controlled by the State or a unit of local government.

b) The Department will select and approve pilot projects for the Forever Green Illinois Program. These pilot projects will be identified and selected by the Department based on geographic size, location, need, local government interest, availability of local government resources, available funding, available contractors, and available Department staffing.

c) Pilot projects may be conducted in one or more of the following counties: Cook, DeKalb, Jefferson, McDonough, McLean, Sangamon and St. Clair.

Section 241.40 Priority to Existing Tree City USA Communities

To assist the Department in establishing the pilot projects, existing Tree City USA communities shall be given priority for participation in the Forever Green Illinois Program.

Section 241.50 Government Record of Problem Trees

A participating entity shall maintain a prioritized list of problem trees. The participating entity shall make this record available to the Department.

Section 241.60 Tree Removal and Greenery Placement

a) After reviewing the participating entity's prioritized list of problem trees, the Department will determine the number of trees to be removed, as well as the number and type of trees and other greenery to be planted back on the public property.

b) The Department may enter into intergovernmental agreements with participating entities whereby the participating entities would allow the Department's approved and credentialed contractors to remove up to 150 problem trees located on public property and to replace the removed trees with an appropriate combination of trees and/or other greenery from predetermined lists. The predetermined lists are entitled "Increasing Tree Diversity in the Urban Landscape – Northern Illinois", "Increasing Tree Diversity in the Urban Landscape – Central Illinois", and "Increasing Tree Diversity in the Urban Landscape – Southern Illinois" (revised 11/27/07) and are available from the Department at http://www.agr.state.il.us/eab/PDFs_for_web/Reforestation/Northern_IL.pdf, http://www.agr.state.il.us/eab/PDFs_for_web/Reforestation/Central_IL.pdf, and http://www.agr.state.il.us/eab/PDFs_for_web/Reforestation/Southern_IL.pdf, respectively.

c) The Department may enter into intergovernmental agreements with participating entities whereby the participating entities would allow the Department's approved and credentialed contractors to place greenery on property owned or controlled by the participating entities.

d) The participating entity shall be responsible for the removal and/or repair of any infrastructure that would be disturbed as a result of the tree removal or greenery placement process, such as, but not limited to, sidewalks, pavement and curbing.

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Permits

2) Code Citation: 35 Ill. Adm. Code 652

3) Section Number: 652.111 — Proposed Action: Amend

4) Statutory Authority: Implementing and authorized by Section 14 through 19 of the Illinois Environmental Protection [415 ILCS 5/14 through 19]

5) A Complete Description of the Subjects and Issues Involved: The Illinois EPA's proposed amendment to Section 652.111 allows the Agency to issue construction permits to a community water supply even if the community water supply is in violation of the Environmental Protection Act or regulations when the requested permit is for the construction or installation of equipment necessary to produce water that is assuredly safe as required by Section 601.101 of Title 35 of the Illinois Administrative Code.

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

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

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

9) Does this proposed rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: This rulemaking will not create or expand a State mandate under the State Mandates Act [30 ILCS 805].

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on the proposed rules may submit them in writing by no later than 45 days after publication of this Notice to:

Rex L. Gradeless
Assistant Counsel
Illinois Environmental Protection Agency
Division of Legal Counsel

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENT

1021 North Grand Avenue East
P.O. Box 19276
Springfield IL 62794-9276

217/524-3332
Rex.Gradeless@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Any small businesses, small municipalities or not for profit corporations that are community water supplies as defined by the Illinois Environmental protection Act, 415 ILCS 5/ 3.145, may be affected by these proposed rules.

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: This rule was not included on either of the 2 most recent agendas because the Agency only recently became aware of the regulatory gap between 35 Ill. Adm. Code 601.101 and 35 Ill. Adm. Code 652.111.

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

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENT

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE F: PUBLIC WATER SUPPLIES
CHAPTER II: ENVIRONMENTAL PROTECTION AGENCY

PART 652
PERMITS

SUBPART A: CONSTRUCTION PERMITS

Section
652.101 Construction Permit Requirements
652.102 Submission of Plans and Specifications
652.103 Preliminary Plans
652.104 Supporting Data for Construction Permit Applications
652.105 Plans – General Layout
652.106 Specifications
652.107 Revisions to Plan Documents
652.108 Alterations
652.109 Filing of Applications and Final Action by Agency
652.110 Permit Application Review
652.111 Standards for Issuance
652.112 Duration of Permits
652.113 Permit Limitations
652.114 Right of Inspection

SUBPART B: OPERATING PERMITS

Section
652.201 Operating Permit Requirements
652.202 Certified Operator or Registered Person
652.203 Projects Requiring Disinfection
652.204 Projects Not Requiring Disinfection
652.205 Partial Operating Permits

SUBPART C: EMERGENCY PERMITS

Section
652.301 Permits Under Emergency Conditions

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENT

SUBPART D: RESTRICTED STATUS AND CRITICAL REVIEW

Section
652.401 Basis of Restricted Status and Critical Review
652.402 Notification of Restricted Status or Critical Review Status

SUBPART E: ALGICIDE PERMITS

Section
652.501 Algicide Permit Requirements
652.502 Permit Applications
652.503 Sampling

SUBPART F: AQUATIC PESTICIDE PERMITS

Section
652.601 Aquatic Pesticide Permit Requirements
652.602 Permit Application Contents
652.603 Permits Under Public Health Related Emergencies
652.604 State Agency Programs
652.605 Extension of Permit Duration

SUBPART G: PUBLIC WATER SUPPLY CAPACITY

Section
652.701 System Capacity
652.702 Supporting Data for Public Water Supply Capacity Demonstration

AUTHORITY: Implementing and authorized by Sections 14 through 19 of the Illinois Environmental Protection Act [415 ILCS 5/14 through 19] (see PA 90-773).

SOURCE: Adopted December 30, 1974; amended at 2 Ill. Reg. 51, p. 219, effective December 17, 1978; rules repealed and new rules adopted and codified at 5 Ill. Reg. 2705, effective March 4, 1981; rules repealed and new rules adopted and codified at 8 Ill. Reg. 8455, effective June 5, 1984; amended at 23 Ill. Reg. 8989, effective July 29, 1999; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: CONSTRUCTION PERMITS

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED AMENDMENT

Section 652.111 Standards for Issuance

a) The Agency shall issue a construction permit if documents show that:

1) the community water supply will be constructed, modified or operated so that it will not cause a violation of the Illinois Environmental Protection Act [415 ILCS 5] or 35 Ill. Adm. Code: Subtitle F, Chapter I;

2) construction will be in accordance with the Agency Rules for Public Water Supplies (35 Ill. Adm. Code 651 through 654), the American Water Works Association (AWWA) Standards and the "Standards" (as defined in 35 Ill. Adm. Code 651.102); and

3) notification of ownership pursuant to 35 Ill. Adm. Code 603.101 is on file.

b) In case of conflict among the documents in subsection (a)(2) ~~above~~, the Agency Rules for Public Water Supplies shall be complied with.

c) The existence of a violation of the Act or a regulation will not prevent the issuance of a construction permit if:

1) the applicant has been granted a variance or an adjusted standard from ~~the~~ regulation by the Board;

2) the permit application is for construction or installation of equipment to alleviate or correct a violation; ~~or~~

3) the permit application is for a water main extension to serve existing residences or commercial facilities when ~~where~~ the permit applicant can show that those residences or commercial facilities are being served by a source of water of a quality or quantity that ~~which~~ violates the finished water standards of 35 Ill. Adm. Code 611; or

4) the Agency determines the permit application is for construction or installation of equipment necessary to produce water that is assuredly safe, as required by 35 Ill. Adm. Code 601.101.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Medical Payment

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

3)

Section Numbers:	Proposed Action:
140.11	Amend
140.16	Amend
140.71	Amend
140.402	Amend
140.459	Amend
140.461	Amend
140.462	Amend
140.464	Amend
140.930	Amend
140.Table J	New
140.Table M	Repeal

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11].

5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the SMART Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

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

7) Will this rulemaking replace any emergency rule currently in effect? Yes

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

9) Does this rulemaking contain incorporation by reference? No

10) Are there any other rulemakings pending on this Part? Yes

Sections	Proposed Action	*Illinois Register* Citation
140.462	Amendment	37 Ill. Reg. 12637; August 16, 2013
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.2	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.3	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.6	Amendment	38 Ill. Reg. 2529; January 17, 2014
140.441	Amendment	38 Ill. Reg. 2529; January 17, 2014

11) Statement of Statewide Policy Objective: These proposed amendments neither create nor expand any State mandate affecting units of local government.

12) Information and questions regarding this amendment shall be directed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@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].

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 2014

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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

PART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

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

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Suspension and Denial of Payment, Recovery of Money and Penalties
140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination, Suspension, Exclusion or Revocation on Persons

Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension, Exclusion or Barring
140.20 Submittal of Claims
140.21 Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
140.22 Magnetic Tape Billings (Repealed)
140.23 Payment of Claims
140.24 Payment Procedures
140.25 Overpayment or Underpayment of Claims
140.26 Payment to Factors Prohibited
140.27 Assignment of Vendor Payments
140.28 Record Requirements for Medical Providers
140.30 Audits
140.31 Emergency Services Audits
140.32 Prohibition on Participation, and Special Permission for Participation
140.33 Publication of List of Sanctioned Entities
140.35 False Reporting and Other Fraudulent Activities
140.40 Prior Approval for Medical Services or Items
140.41 Prior Approval in Cases of Emergency
140.42 Limitation on Prior Approval
140.43 Post Approval for Items or Services When Prior Approval Cannot Be Obtained
140.44 Withholding of Payments Due to Fraud or Misrepresentation
140.45 Withholding of Payments Upon Provider Audit, Quality of Care Review, Credible Allegation of Fraud or Failure to Cooperate
140.55 Electronic Data Interchange Service
140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
140.72 Drug Manual (Recodified)
140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

Section
140.80 Hospital Provider Fund
140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust

	Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95	Hospital Services Trust Fund
140.96	General Requirements (Recodified)
140.97	Special Requirements (Recodified)
140.98	Covered Hospital Services (Recodified)
140.99	Hospital Services Not Covered (Recodified)
140.100	Limitation On Hospital Services (Recodified)
140.101	Transplants (Recodified)
140.102	Heart Transplants (Recodified)
140.103	Liver Transplants (Recodified)
140.104	Bone Marrow Transplants (Recodified)
140.110	Disproportionate Share Hospital Adjustments (Recodified)
140.116	Payment for Inpatient Services for GA (Recodified)
140.117	Hospital Outpatient and Clinic Services (Recodified)
140.200	Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201	Payment for Hospital Services After June 30, 1982 (Repealed)
140.202	Payment for Hospital Services During Fiscal Year 1983 (Recodified)
140.203	Limits on Length of Stay by Diagnosis (Recodified)
140.300	Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
140.350	Copayments (Recodified)
140.360	Payment Methodology (Recodified)
140.361	Non-Participating Hospitals (Recodified)
140.362	Pre July 1, 1989 Services (Recodified)
140.363	Post June 30, 1989 Services (Recodified)
140.364	Prepayment Review (Recodified)
140.365	Base Year Costs (Recodified)
140.366	Restructuring Adjustment (Recodified)
140.367	Inflation Adjustment (Recodified)
140.368	Volume Adjustment (Repealed)
140.369	Groupings (Recodified)
140.370	Rate Calculation (Recodified)
140.371	Payment (Recodified)
140.372	Review Procedure (Recodified)
140.373	Utilization (Repealed)
140.374	Alternatives (Recodified)
140.375	Exemptions (Recodified)
140.376	Utilization, Case-Mix and Discretionary Funds (Repealed)
140.390	Subacute Alcoholism and Substance Abuse Services (Recodified)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.391 Definitions (Recodified)
140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section
140.400 Payment to Practitioners
140.402 Copayments for Noninstitutional Medical Services
140.403 Telehealth Services
140.405 Non-Institutional Rate Reductions
140.410 Physicians' Services
140.411 Covered Services By Physicians
140.412 Services Not Covered By Physicians
140.413 Limitation on Physician Services
140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items – Prescribers
140.416 Optometric Services and Materials
140.417 Limitations on Optometric Services
140.418 Department of Corrections Laboratory
140.420 Dental Services
140.421 Limitations on Dental Services
140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)
140.425 Podiatry Services
140.426 Limitations on Podiatry Services
140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items – Podiatry (Repealed)
140.428 Chiropractic Services
140.429 Limitations on Chiropractic Services (Repealed)
140.430 Independent Clinical Laboratory Services
140.431 Services Not Covered by Independent Clinical Laboratories
140.432 Limitations on Independent Clinical Laboratory Services
140.433 Payment for Clinical Laboratory Services
140.434 Record Requirements for Independent Clinical Laboratories
140.435 Advanced Practice Nurse Services
140.436 Limitations on Advanced Practice Nurse Services

140.438 Diagnostic Imaging Services
140.440 Pharmacy Services
140.441 Pharmacy Services Not Covered
140.442 Prior Approval of Prescriptions
140.443 Filling of Prescriptions
140.444 Compounded Prescriptions
140.445 Legend Prescription Items (Not Compounded)
140.446 Over-the-Counter Items
140.447 Reimbursement
140.448 Returned Pharmacy Items
140.449 Payment of Pharmacy Items
140.450 Record Requirements for Pharmacies
140.451 Prospective Drug Review and Patient Counseling
140.452 Mental Health Services
140.453 Definitions
140.454 Types of Mental Health Services
140.455 Payment for Mental Health Services
140.456 Hearings
140.457 Therapy Services
140.458 Prior Approval for Therapy Services
140.459 Payment for Therapy Services
140.460 Clinic Services
140.461 Clinic Participation, Data and Certification Requirements
140.462 Covered Services in Clinics
140.463 Clinic Service Payment
140.464 Hospital-Based and Encounter Rate Clinic Payments
140.465 Speech and Hearing Clinics (Repealed)
140.466 Rural Health Clinics (Repealed)
140.467 Independent Clinics
140.469 Hospice
140.470 Eligible Home Health Care, Nursing and Public Health Providers
140.471 Description of Home Health Care Services
140.472 Types of Home Health Care Services
140.473 Prior Approval for Home Health Care Services
140.474 Payment for Home Health Care Services
140.475 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
140.476 Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices for Which Payment Will Not Be Made
140.477 Limitations on Equipment, Prosthetic Devices and Orthotic Devices

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.478 Prior Approval for Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices
140.479 Limitations, Medical Supplies
140.480 Equipment Rental Limitations
140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids
140.482 Family Planning Services
140.483 Limitations on Family Planning Services
140.484 Payment for Family Planning Services
140.485 Healthy Kids Program
140.486 Illinois Healthy Women
140.487 Healthy Kids Program Timeliness Standards
140.488 Periodicity Schedules, Immunizations and Diagnostic Laboratory Procedures
140.490 Medical Transportation
140.491 Limitations on Medical Transportation
140.492 Payment for Medical Transportation
140.493 Payment for Helicopter Transportation
140.494 Record Requirements for Medical Transportation Services
140.495 Psychological Services
140.496 Payment for Psychological Services
140.497 Hearing Aids
140.498 Fingerprint-Based Criminal Background Checks

SUBPART E: GROUP CARE

Section
140.500 Long Term Care Services
140.502 Cessation of Payment at Federal Direction
140.503 Cessation of Payment for Improper Level of Care
140.504 Cessation of Payment Because of Termination of Facility
140.505 Informal Hearing Process for Denial of Payment for New ICF/MR
140.506 Provider Voluntary Withdrawal
140.507 Continuation of Provider Agreement
140.510 Determination of Need for Group Care
140.511 Long Term Care Services Covered By Department Payment
140.512 Utilization Control
140.513 Notification of Change in Resident Status
140.514 Certifications and Recertifications of Care (Repealed)
140.515 Management of Recipient Funds – Personal Allowance Funds
140.516 Recipient Management of Funds

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.517 Correspondent Management of Funds
140.518 Facility Management of Funds
140.519 Use or Accumulation of Funds
140.520 Management of Recipient Funds – Local Office Responsibility
140.521 Room and Board Accounts
140.522 Reconciliation of Recipient Funds
140.523 Bed Reserves
140.524 Cessation of Payment Due to Loss of License
140.525 Quality Incentive Program (QUIP) Payment Levels
140.526 County Contribution to Medicaid Reimbursement (Repealed)
140.527 Quality Incentive Survey (Repealed)
140.528 Payment of Quality Incentive (Repealed)
140.529 Reviews (Repealed)
140.530 Basis of Payment for Long Term Care Services
140.531 General Service Costs
140.532 Health Care Costs
140.533 General Administration Costs
140.534 Ownership Costs
140.535 Costs for Interest, Taxes and Rent
140.536 Organization and Pre-Operating Costs
140.537 Payments to Related Organizations
140.538 Special Costs
140.539 Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation
140.540 Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
140.541 Salaries Paid to Owners or Related Parties
140.542 Cost Reports – Filing Requirements
140.543 Time Standards for Filing Cost Reports
140.544 Access to Cost Reports (Repealed)
140.545 Penalty for Failure to File Cost Reports
140.550 Update of Operating Costs
140.551 General Service Costs Updates
140.552 Nursing and Program Costs
140.553 General Administrative Costs Updates
140.554 Component Inflation Index (Repealed)
140.555 Minimum Wage
140.560 Components of the Base Rate Determination

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.561 Support Costs Components
140.562 Nursing Costs
140.563 Capital Costs
140.565 Kosher Kitchen Reimbursement
140.566 Out-of-State Placement
140.567 Level II Incentive Payments (Repealed)
140.568 Duration of Incentive Payments (Repealed)
140.569 Clients With Exceptional Care Needs
140.570 Capital Rate Component Determination
140.571 Capital Rate Calculation
140.572 Total Capital Rate
140.573 Other Capital Provisions
140.574 Capital Rates for Rented Facilities
140.575 Newly Constructed Facilities (Repealed)
140.576 Renovations (Repealed)
140.577 Capital Costs for Rented Facilities (Renumbered)
140.578 Property Taxes
140.579 Specialized Living Centers
140.580 Mandated Capital Improvements (Repealed)
140.581 Qualifying as Mandated Capital Improvement (Repealed)
140.582 Cost Adjustments
140.583 Campus Facilities
140.584 Illinois Municipal Retirement Fund (IMRF)
140.590 Audit and Record Requirements
140.642 Screening Assessment for Nursing Facility and Alternative Residential Settings and Services
140.643 In-Home Care Program
140.645 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21 (Repealed)
140.646 Reimbursement for Developmental Training (DT) Services for Individuals With Developmental Disabilities Who Reside in Long Term Care (ICF and SNF) and Residential (ICF/MR) Facilities
140.647 Description of Developmental Training (DT) Services
140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs
140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs
140.650 Certification of Developmental Training (DT) Programs
140.651 Decertification of Day Programs
140.652 Terms of Assurances and Contracts

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.680 Effective Date Of Payment Rate
140.700 Discharge of Long Term Care Residents
140.830 Appeals of Rate Determinations
140.835 Determination of Cap on Payments for Long Term Care (Repealed)

SUBPART F: FEDERAL CLAIMING FOR STATE AND LOCAL GOVERNMENTAL ENTITIES

Section
140.850 Reimbursement of Administrative Expenditures
140.855 Administrative Claim Review and Reconsideration Procedure
140.860 County Owned or Operated Nursing Facilities
140.865 Sponsor Qualifications (Repealed)
140.870 Sponsor Responsibilities (Repealed)
140.875 Department Responsibilities (Repealed)
140.880 Provider Qualifications (Repealed)
140.885 Provider Responsibilities (Repealed)
140.890 Payment Methodology (Repealed)
140.895 Contract Monitoring (Repealed)
140.896 Reimbursement For Program Costs (Active Treatment) For Clients in Long Term Care Facilities For the Developmentally Disabled (Recodified)
140.900 Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Recodified)
140.901 Functional Areas of Needs (Recodified)
140.902 Service Needs (Recodified)
140.903 Definitions (Recodified)
140.904 Times and Staff Levels (Repealed)
140.905 Statewide Rates (Repealed)
140.906 Reconsiderations (Recodified)
140.907 Midnight Census Report (Recodified)
140.908 Times and Staff Levels (Recodified)
140.909 Statewide Rates (Recodified)
140.910 Referrals (Recodified)
140.911 Basic Rehabilitation Aide Training Program (Recodified)
140.912 Interim Nursing Rates (Recodified)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.920 General Description
140.922 Covered Services
140.924 Maternal and Child Health Provider Participation Requirements
140.926 Client Eligibility (Repealed)
140.928 Client Enrollment and Program Components (Repealed)
140.930 Reimbursement
140.932 Payment Authorization for Referrals (Repealed)

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

Section
140.940 Illinois Competitive Access and Reimbursement Equity (ICARE) Program (Recodified)
140.942 Definition of Terms (Recodified)
140.944 Notification of Negotiations (Recodified)
140.946 Hospital Participation in ICARE Program Negotiations (Recodified)
140.948 Negotiation Procedures (Recodified)
140.950 Factors Considered in Awarding ICARE Contracts (Recodified)
140.952 Closing an ICARE Area (Recodified)
140.954 Administrative Review (Recodified)
140.956 Payments to Contracting Hospitals (Recodified)
140.958 Admitting and Clinical Privileges (Recodified)
140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
140.964 Contract Monitoring (Recodified)
140.966 Transfer of Recipients (Recodified)
140.968 Validity of Contracts (Recodified)
140.970 Termination of ICARE Contracts (Recodified)
140.972 Hospital Services Procurement Advisory Board (Recodified)
140.980 Elimination Of Aid To The Medically Indigent (AMI) Program (Emergency Expired)
140.982 Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age (Emergency Expired)

SUBPART I: PRIMARY CARE CASE MANAGEMENT PROGRAM

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section
140.990 Primary Care Case Management Program
140.991 Primary Care Provider Participation Requirements
140.992 Populations Eligible to Participate in the Primary Care Case Management Program
140.993 Care Management Fees
140.994 Panel Size and Affiliated Providers
140.995 Mandatory Enrollment
140.996 Access to Health Care Services
140.997 Payment for Services

SUBPART J: ALTERNATE PAYEE PARTICIPATION

Section
140.1001 Registration Conditions for Alternate Payees
140.1002 Participation Requirements for Alternate Payees
140.1003 Recovery of Money for Alternate Payees
140.1004 Conditional Registration for Alternate Payees
140.1005 Revocation of an Alternate Payee

SUBPART K: MANDATORY MCO ENROLLMENT

140.1010 Mandatory Enrollment in MCOs

SUBPART L: UNAUTHORIZED USE OF MEDICAL ASSISTANCE

Section
140.1300 Definitions
140.1310 Recovery of Money
140.1320 Penalties
140.1330 Enforcement

140.TABLE A Criteria for Non-Emergency Ambulance Transportation
140.TABLE B Geographic Areas
140.TABLE C Capital Cost Areas
140.TABLE D Schedule of Dental Procedures
140.TABLE E Time Limits for Processing of Prior Approval Requests
140.TABLE F Podiatry Service Schedule (Repealed)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

140.TABLE G	Travel Distance Standards
140.TABLE H	Areas of Major Life Activity
140.TABLE I	Staff Time and Allocation for Training Programs (Recodified)
140.TABLE J	Rate Regions~~HSA Grouping (Repealed)~~
140.TABLE K	Services Qualifying for 10% Add-On (Repealed)
140.TABLE L	Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
140.TABLE M	Enhanced Rates for Maternal and Child Health Provider Services (Repealed)

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

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a

maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940

thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990;

amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment

suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective

September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective

November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; peremptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days;

emergency expired April 10, 2009; peremptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011; amended at 35 Ill. Reg. 7962, effective May 1, 2011; amended at 35 Ill. Reg. 10000, effective June 15, 2011; amended at 35 Ill. Reg. 12909, effective July 25, 2011; amended at 36 Ill. Reg. 2271, effective February 1, 2012; amended at 36 Ill. Reg. 7010, effective April 27, 2012; amended at 36 Ill. Reg. 7545, effective May 7, 2012; amended at 36 Ill. Reg. 9113, effective June 11, 2012; emergency amendment at 36 Ill. Reg. 11329, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 140.442(e)(4) suspended at 36 Ill. Reg. 13736, effective August 15, 2012; suspension withdrawn from Section 140.442(e)(4) at 36 Ill. Reg. 14529, September 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.442(e)(4) at 36 Ill. Reg. 14820, effective September 21, 2012 through June 30, 2013; emergency amendment to Section 140.491 suspended at 36 Ill. Reg. 13738, effective August 15, 2012; suspension withdrawn by the Joint Committee on Administrative Rules from Section 140.491 at 37 Ill. Reg. 890, January 8, 2013; emergency amendment in response to Joint Committee on Administrative Rules action on Section 140.491 at 37 Ill. Reg. 1330, effective January 15, 2013 through June 30, 2013; amended at 36 Ill. Reg. 15361, effective October 15, 2012; emergency amendment at 37 Ill. Reg. 253, effective January 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 846, effective January 9, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 1774, effective January 28, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 2348, effective February 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 3831, effective March 13, 2013; emergency amendment at 37 Ill. Reg. 5058, effective April 1, 2013 through June 30, 2013; emergency amendment at 37 Ill. Reg. 5170, effective April 8, 2013 through June 30, 2013; amended at 37 Ill. Reg. 6196, effective April 29, 2013; amended at 37 Ill. Reg. 7985, effective May 29, 2013; amended at 37 Ill. Reg. 10282, effective June 27, 2013; amended at 37 Ill. Reg. 12855, effective July 24, 2013; emergency amendment at 37 Ill. Reg. 14196, effective August 20, 2013, for a maximum of 150 days; amended at 37 Ill. Reg. 17584, effective October 23,

2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 4330, effective January 29, 2014; amended at 38 Ill. Reg. _____, effective _____.

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.11 Enrollment Conditions for Medical Providers

a) In order to enroll for participation, providers shall:

1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors.~~;~~

2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation.~~;~~

3) Be certified for Title XIX when federal or State rules and regulations so require.~~;~~

4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted.~~;~~

5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients.~~; and~~

6) Have a written provider agreement on file with the Department.

b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location;

therefore, participation approval is not transferable.

c) Except for children's hospitals described at 89 Ill. Adm. Code 148.25(d)(3)(B)~~149.50(c)(3)~~, hospitals providing inpatient care that are certified under a single Centers for Medicare and Medicaid Services certification~~Medicare~~ number shall be enrolled as a single~~an individual~~ entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.

d) Upon notification from the Illinois Department of Public Health of a change of ownership, the Department shall notify the prospective buyer of its obligation under Section 140.12(l) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.

e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such information within the requested time frames will result in the disenrollment~~dis-enrollment~~ of the provider from the Program. Such disenrollment~~dis-enrollment~~ shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A disenrolled~~dis-enrolled~~ provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.

f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application

for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.

g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a vendor is subject to a provisional period and shall be conditional for one year unless limited by the Department. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the Medical Assistance Program without cause. Upon termination of a vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:

1) Individuals~~individuals~~ with management responsibility;

2) All~~all~~ owners or partners in a partnership;

3) All~~all~~ officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporation; or

4) An~~an~~ owner of a sole proprietorship.

h) Unless otherwise specified, the termination of eligibility or vendor disenrollment, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.16 Termination, Suspension or Exclusion of a Vendor's Eligibility to Participate in the Medical Assistance Program

a) The~~Effective July 1, 2012, the~~ Department may terminate or suspend a vendor's eligibility to participate in the Medical Assistance Program, terminate or not renew a vendor's provider agreement, or exclude a person or entity from participation in the Medical Assistance Program, when it determines that, at any time:

1) The vendor is not complying with the Department's policy or rules, or with the terms and conditions prescribed by the Department in any vendor

agreement developed as a result of negotiations with the vendor category, or with the covenants contained in certifications bearing the vendor's signature on claims submitted to the Department by the vendor, or with restrictions on participation imposed pursuant to Section 140.32~~(f)~~;

2) The vendor, person or entity is not properly licensed, certified, authorized or otherwise qualified, or the vendor person's or entity's professional license, certificate or other authorization has not been renewed or has been restricted, revoked, suspended or otherwise terminated as determined by the appropriate licensing, certifying or authorizing agency. The termination, suspension or exclusion shall be immediately effective;

3) The vendor violates records requirements as set forth in statute or Department rules, provider handbooks or policies.

A) The vendor has failed to keep or timely make available for inspection, audit or copying (including photocopying), after receiving a written request from the Department:

i) records required to be maintained by the Department or necessary to fully and completely disclose the extent of the services or supplies provided; or

ii) full and complete records required to be maintained by the Department regarding payments claimed for providing services.

B) This subsection (a)(3) does not require vendors to make available medical records of patients for whom services are not reimbursed under the Illinois Public Aid Code;

4) The vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services, or has failed to furnish all information required by the Department in connection with the rendering of services or supplies to recipients of public assistance by the vendor or his or her agent, employer or employee;

5) The vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the

administration of the Medical Assistance Program. For purposes of this subsection (a)(5), statements or representations made "knowingly" shall include statements or representations made with actual knowledge that they were false as well as those statements made when the individual making the statement had knowledge of such facts or information as would cause one to be aware that the statements or representations were false when made;

6) The vendor has submitted claims for services or supplies that were not rendered or delivered by that vendor;

7) The vendor has furnished goods or services to a recipient that, when based upon competent medical judgment and evaluation, are determined to be:

A) in excess of needs;

B) harmful (for the purpose of this subsection (a)(7)(B), "harmful" goods or services cause actual harm as defined in Section 140.13 or place an individual at risk of harm, or of adverse side effects, that outweigh the medical benefits sought); or

C) of grossly inferior quality;

8) The vendor knew or should have known that a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an investor in the vendor, a technical or other advisor of the vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor was previously terminated, suspended, excluded or barred from participation in the Medical Assistance Program, or in another state or federal medical assistance or health care program;

9) The vendor has a delinquent debt owed to the Department;

10) The vendor engaged in practices prohibited by federal or State law or regulation.

A) The vendor, a person with management responsibility for a vendor,

an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor, either:

i) has engaged in practices prohibited by applicable federal or State law or regulation; or

ii) was a person with management responsibility for a vendor at the time that the vendor engaged in practices prohibited by applicable federal or State law or regulation; or

iii) was an officer, or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a vendor at the time the vendor engaged in practices prohibited by applicable federal or State law or regulation; or

iv) was an owner of a sole proprietorship or partner of a partnership that was a vendor at the time the vendor engaged in practices prohibited by applicable federal or State law or regulation;

B) For purposes of this subsection (a)(10), "applicable federal or State law or regulation" includes, but is not limited to, licensing or certification standards contained in State or federal law or regulations related to the Medical Assistance Program, any other licensing standards as they relate to the vendor's practice or business or any federal or State laws or regulations related to the Medical Assistance Program;

C) For purposes of this subsection (a)(10), conviction or a plea of guilty to activities violative of applicable federal or State law or regulation shall be conclusive proof that those activities were engaged in;

11) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares

of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or a partner in a partnership that is a vendor has been convicted in this or any other State, or in any Federal Court, of any offense not related to the Medical Assistance Program, if the offense constitutes grounds for disciplinary action under the licensing Act applicable to that individual or vendor;

12) The vendor, a person with management responsibility for a vendor, an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, an owner of a sole proprietorship that is a vendor, or partner in a partnership that is a vendor has been convicted in this or any other state, or in any Federal Court, of:

A) murder;

B) a Class X felony under the Illinois Criminal Code of 1961;

C) sexual misconduct that may subject recipients to an undue risk of harm;

D) a criminal offense that may subject recipients to an undue risk of harm;

E) a crime of fraud or dishonesty;

F) a crime involving a controlled substance;

G) a misdemeanor relating to fraud, theft, embezzlement or breach of fiduciary responsibility; or

H) other financial misconduct related to a health care program.

13) The direct or indirect ownership of the terminated, suspended or excluded vendor (including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece,

nephew, cousin or relative by marriage.

b) The Department may suspend a vendor's eligibility to participate in the Medical Assistance Program if the vendor is not in compliance with State income tax requirements, child support payments in accordance with Article X of the Illinois Public Aid Code, or educational loans guaranteed by the Illinois Student Assistance Commission. The vendor may prevent suspension of eligibility by payment of past-due amounts in full or by entering into payment arrangements acceptable to the appropriate State agency.

c) The~~Effective July 1, 2012, the~~ Department may terminate, suspend or exclude vendors who pose a risk of fraud, waste, abuse or harm, as defined in Section 140.13, from participation in the Medical Assistance Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

a) C-13 Invoice Voucher Advance Payments

1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department~~ of Public Aid~~;

B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) agency system errors (either automated system or clerical)

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

ii) cash flow problems encountered by a provider or group of providers which are unrelated to agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospital must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi) for government-owned facilities, this subsection (a)(1)(C) may be waived if the cash flow criterion~~criteria~~ under subsection (a)(1)(B)(ii) is met; and

vii) for providers who have filed for Chapter 11 bankruptcy, this subsection (a)(1)(C) may be waived if the cash flow criterion~~criteria~~ under subsection (a)(1)(B)(ii) are met;

D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

i) specific reasons~~reason(s)~~ for advanced payments;

ii) specific amount agreed to be advanced;

iii) specific date to begin recoupment; and

iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System (MMIS) voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).

2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.

3) Approval Process

A) In order to obtain C-13 advance payments, providers must submit their request in writing (telefacsimile and email~~telefax~~ requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the circumstances creating the need for the advance payments;

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

iii) specification of the amount of the advance required.

B) An agreement will be issued to the provider for all approved

requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.

C) C-13 advance payments shall be authorized for the provider following approval by the ~~Medicaid~~ Administrator of the Division of Medical Programs or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within seven days.

4) Recoupment

A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.

B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six months from the month in which payment is authorized. For those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Department pursuing other collection methods.

5) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section~~rule~~ will remain in effect, notwithstanding the provisions of this Section.

b) Expedited Claims Payments

1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital qualified and participating under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:

A) are enrolled with the Department~~ of Public Aid~~;

B) have experienced an emergency which necessitates expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

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

ii) cash flow problems encountered by a provider or group of providers which are unrelated to Department technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial

problems to a provider adversely impacting on the ability to serve the clients;

C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;

ii) for long term care facilities enrolled in the Exceptional Care Program, four or more residents receiving exceptional care;

iii) for hospitals, the hospitals must qualify as a disproportionate share hospital as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122;

~~iv) for hospitals that qualify as disproportionate share hospitals as described in 89 Ill. Adm. Code 148.120 or receive Medicaid Percentage Adjustment payments as described in 89 Ill. Adm. Code 148.122 and receive Rehabilitation Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(b)) or Direct Hospital Adjustment payments (see 89 Ill. Adm. Code 148.295(c)(1)), a request must be made in writing that demonstrates proof of cash flow problems;~~

iv~~v~~) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;

v~~vi~~) for sole source pharmacies in a community that are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;

vi~~vii~~) for government-owned facilities, this subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) are met; and

vii~~viii~~) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) may be waived if the cash flow criteria under subsection (b)(1)(B)(ii) are met.

2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.

3) Approval Process

A) In order to qualify for expedited payments, providers must submit their request in writing (telefacsimile and email~~telefax~~ requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

i) an explanation of the need for the expedited payments; and

ii) supportive documentation to substantiate the emergency nature of the request.

B) Expedited payments shall be authorized for the provider following approval by the ~~Medicaid~~ Administrator of the Division of Medical Programs or designee.

C) The Department will periodically review the need for any continued expedited payments.

4) Prior Agreements
The terms of any agreement signed between the provider and the Department prior to the adoption of this Section or prior to any amendment to this Section~~rule~~ will remain in effect, notwithstanding the provisions of this Section.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.402 Copayments for Non-institutional Medical Services

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the

Social Security Act):

a) Each~~Effective July 1, 2012, each~~ recipient, with the exception of those classes of recipients identified in subsection (d) of this Section, shall be required to pay a copayment of $2.00 for generic legend drugs and over-the-counter drugs billed to the Department, and for other services, with the exception of those services identified in subsection (e), the nominal copayment amount as defined at 42 CFR 447.54. For dates of service beginning July 1, 2012 through March 31, 2013 the nominal copayment amount is $3.65. Beginning with dates of service on April 1, 2013, the nominal copayment amount is $3.90. Specific copayment amounts are described and updated on the Department's Web site for the following non-institutional medical services:

1) Office visits to enrolled practitioners for services reimbursed under the Illinois Public Aid Code.

2) Each brand name legend drug billed to the Department.

3) Each encounter billed to the Department by an Encounter Rate Clinic (ERC), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), but excluding behavioral services provided by these facilities. For dates of service beginning July 1, 2013, copayments for behavioral health services provided by these facilities are no longer excluded and shall be required to be paid by recipients with the exception of those classes of recipients identified in subsection (d).

b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the respective amount of the required copayment.

c) No provider of services listed in subsection (a) may deny service to an individual who is eligible for service on account of the individual's inability to pay the cost of a copayment.

d) The following individuals receiving medical assistance are exempt from the copayment requirement set forth in subsection (a):

1) Pregnant women, including a postpartum period of 60 days.

2) Children under 19 years of age.

3) All non-institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections.

4) Hospice patients.

5) Individuals residing in hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled who, as a condition of receiving services, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their care. For the purpose of this subsection (d)(5), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).

6) Residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, for the cost of their residential care program. For the purpose of this subsection (d)(6), the protected amount shall be no greater than the protected amount authorized for personal use under 89 Ill. Adm. Code 146.225(c).

7) Individuals enrolled in the "Health Benefits for Person with Breast or Cervical Cancer" program under 89 Ill. Adm. Code 120.500.

8) American Indians or Alaskan Natives.

e) The following medical services are exempt from any copayments:

1) Renal dialysis treatment.

2) Radiation therapy.

3) Cancer chemotherapy.

4) Insulin.

5) Services for which Medicare is the primary payer.

6) Emergency services as defined at 42 USC 1396u-2(b)(2) (section 1932(b)(2) of the Social Security Act) and 42 CFR 438.114(a).

7) Any pharmacy compounded drugs.

8) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.

9) Family planning services and supplies described in 42 USC 1396d(a)(4)(C) (section 1905(a)(4)(C) of the Social Security Act), including contraceptives and other pharmaceuticals for which the State claims or could claim federal financial participation~~match~~ at the enhanced rate under 42 USC 1396b(a)(5) (section 1903(a)(5) of the Social Security Act) for family planning services and supplies.

10) Other therapeutic drug classes as specified by the Department.

11) Preventive services as described in section 4106(b) of the Affordable Care Act.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.459 Payment for Therapy Services

a) Therapy services shall be paid at an all-inclusive ~~per half-hour~~ rate that~~which~~ shall be the lower of:

1~~a~~) The provider's~~providers~~ usual and customary charge for services.~~; of~~

2~~b~~) The maximum reimbursement rate established by the Department.

b) Maximum Reimbursement Rates. The maximum reimbursement rate:

1) For outpatient physical rehabilitation services provided by a hospital (paid per visit and limited to one visit per day):

A) That is a children's hospital, as defined in Section 148.25(d)(3)(A), enrolled with the Department to provide outpatient physical rehabilitation shall be $130.00.

B) Enrolled with the Department to provide outpatient physical rehabilitation shall be $130.00.

C) Not enrolled with the Department to provide outpatient physical rehabilitation shall be $115.00.

2) For all other therapy services (paid per quarter hour) shall be as published in fee schedules on the Department's website.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.461 Clinic Participation, Data and Certification Requirements

a) Hospital-based organized clinics must:

1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care.~~;~~

2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers.~~;~~

3) Meet one of the following requirements:

A) Be~~be~~ adjacent to or on the premises of a~~the~~ hospital:~~and be~~

i) licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or

ii) that meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

B) Have~~have~~ provider-based status under Medicare pursuant to 42 CFR 413.65.~~; or~~

C) Be~~be~~ clinically integrated as evidenced by all of the following:

i) Professional~~professional~~ staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital.~~; and~~

ii) Fully~~fully~~ integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic.~~; and~~

iii) Held~~held~~ out to the public and other payers as part of the main hospital.~~; and~~

iv) Operated~~operated~~ under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe

benefits or code of conduct), and final approval for medical staff appointments in the clinic.~~; and~~

v) Located~~located~~ within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.

4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).

b) Encounter Rate Clinics

1) Encounter rate clinics must:

A) have participated~~ participate~~ in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998;~~,~~ or

B) be a clinic operated by an Illinois~~a~~ county with a population of over three million.

2) Individual practitioners associated with these clinics~~such centers~~ may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).

c) Rural health clinics must be certified by the Centers for Medicare and Medicaid Services~~Health Care Financing Administration~~ as meeting the requirements for Medicare participation.

d) Federally Qualified Health Centers (FQHC):

1) Must meet one of the following criteria~~be Health Centers which~~:

A) Receive~~receive~~ a grant under Section 329, 330 or 340 of the Public Health Service Act (42 USC 329, 330 or 340).~~; or~~

B) Based~~based~~ on the recommendation of the Health Resources and Services Administration within the U.S. Department of Health and Human Services~~Public Health Service~~, be~~are~~ determined to meet

the requirements for receiving ~~such~~ a grant.

2) ~~Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which amended~~ Section 1902(a)(55) of the Social Security Act (42 USC ~~Section~~ 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. These sites are~~Such a site is~~ referred to as outstations~~an outstation~~.

A) Outstations will be located at those FQHCs that~~which~~ the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS Family Community Resource Center (FCRC)~~local office~~ will continue to be the application location.

B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS FCRC~~local office~~. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or ineligibility. The DHS FCRC~~local office~~ is responsible for these functions.

C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:

i) Salary of outstation worker.~~;~~

ii) Fringe benefits.~~;~~

iii) Training.~~;~~

iv) Travel.~~; and~~

v) Supplies.

D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.

E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.

F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and auditing purposes.

G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.

H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

~~f) Maternal and Child Health Clinics~~

~~1) Types of Clinics~~
~~The following clinics shall qualify as Maternal and Child Health Clinics:~~

~~A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC) that are hospital-based organized outpatient clinics, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50 percent of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHAPCC must be for primary care.~~

~~B) Certified Hospital Organized Satellite Clinics (CHOSC) that are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a), because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50 percent of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50 percent of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized~~

~~expertise necessary for the provision of secondary and tertiary care. CHOSCs shall meet the requirements in subsections (a)(1) and (a)(2).~~

~~C)~~ ~~Certified Obstetrical Ambulatory Care Centers (COBACC) that are hospital-based organized clinic entities, as described in subsection (a), meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.~~

~~D)~~ ~~Certified Pediatric Ambulatory Care Centers (CPACC) that are hospital-based organized clinic entities, as described in subsection (a), owned and operated by a hospital as described in 89 Ill. Adm. Code 149.50(e)(3), and meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5), that, through staff and supporting resources, provide pediatric primary care and specialty services as described in Section 140.462(e)(3)(C) to Medicaid enrolled children with specialty needs, from birth through 20 years of age in an outpatient setting. Hospitals with CPACCs must also provide primary care for at least 1,500 children, either through its CPACC or through a CHAPCC, CHOSC or encounter rate clinic operated by the same hospital. Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.~~

~~2)~~ ~~General Participation Requirements~~
~~In addition to the Maternal and Child Health participation requirements described in Section 140.924(a)(1), the Maternal and Child Health clinics identified in subsection (f)(1) must:~~

~~A)~~ ~~Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of~~

~~hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 pregnant women or children; or be a primary care teaching site of an organized academic department of:~~

~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.~~

~~ii) In the case of clinics described in subsection (f)(1)(C), an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~

~~iii) In the case of clinics described in subsection (f)(1)(D), a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.~~

~~B) Under the direction of a board certified/eligible physician who has hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:~~

~~i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B), primary care.~~

~~ii) In the case of clinics described in subsection (f)(1)(C), obstetric and specialty services.~~

~~iii) In the case of clinics described in subsection (f)(1)(D), primary care and specialty services.~~

~~C) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation~~

~~of Health Care Organizations (JCAHO);~~

~~D) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department; and~~

~~E) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality.~~

~~3) Special Participation Requirements~~
~~In addition to the Maternal and Child Health provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2), special participation requirements shall apply as follows:~~

~~A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) must:~~

~~i) Serve a total population that includes at least 20 percent Medicaid and medically indigent clients;~~

~~ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and~~

~~iii) Provide or arrange for specialty services when needed by pregnant women or children.~~

~~B) Clinics described in subsection (f)(1)(C) must:~~

~~i) Be a distinct department of a hospital that also operates as a Level II, Level II with Extended Neonatal Capabilities or Level III perinatal center;~~

~~ii) Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to~~

~~women who currently are Medicaid clients, or Medicaid-eligible women who receive services at the COBACC; in this capacity, COBACCs, as perinatal centers, shall serve pregnant women determined to be at high risk of abnormal delivery;~~

~~iii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;~~

~~iv) Have an established program of services for the treatment of substance-abusing pregnant women;~~

~~v) Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and~~

~~vi) Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.~~

~~C) Clinics described in subsection (f)(1)(D) must:~~

~~i) Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C);~~

~~ii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of pediatric emergencies;~~

~~iii) Provide access to necessary pediatric primary and specialty services within 24 hours after referral;~~

~~iv) Be a distinct department of a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120(a)(5);~~

~~v) Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and~~

~~vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.~~

~~4) Data Requirements~~
~~The Maternal and Child Health clinics described in subsection (f)(1) shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.~~

~~5) Certification Requirements~~
~~Certification of qualifying status of a Maternal and Child Health clinic identified in subsection (f)(1) shall occur annually during the first two years of participation and every other year thereafter. In addition:~~

~~A) The certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process.~~

~~B) Entities interested in becoming a Maternal and Child Health clinic must direct a written request for an application packet to the following address:~~

~~Maternal and Child Health Clinic Certification~~
~~Bureau of Comprehensive Health Services~~
~~Illinois Department of Public Aid~~
~~201 South Grand Avenue East, Concourse~~
~~Springfield, Illinois 62763-0001~~

~~C) Certification status shall be suspended for Maternal and Child Health clinics identified in subsection (f)(1) that do not submit data to the Department, as required under subsection (f)(4), within 180 days after the Department's request for the submittal of such data.~~

f~~g~~) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:

1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.

2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.

3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners ~~(see Section 140.400)~~, must be under the direction of a physician.

4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.

5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will

provide ongoing monitoring to assure that appropriate standards are followed.

6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.

7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.

8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.

10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.

A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.

B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.

11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.

12) Data Requirements
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

g~~h~~) Hospital Outpatient Departments
Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

h) County-operated Outpatient Facilities
A county-operated outpatient facility is a non-hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.

1) Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility that is within or adjacent to a large public hospital as defined in 89 Ill. Adm. Code 148.25(a)(1).

2) County Ambulatory Health Centers. A county ambulatory health center is a county-operated outpatient facility that is not a critical clinic provider.

3) County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.462 Covered Services in Clinics

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics

~~1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.~~

1~~2~~) Covered~~With respect to all other hospital-based organized clinics, covered~~ services ~~are those~~ described in 89 Ill. Adm. Code 148.

2~~3~~) Group psychotherapy services meeting~~must meet~~ the guidelines set forth in Section 140.413(a)(4)(C).

b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924~~(a)(2)(B)~~, covered services are those described in Section 140.922.

2) With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

c) Rural Health Clinics
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) speech and hearing services;

I) x-ray services;

J) health education;

K) nutrition services;

L) optometric services.

4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

5) Any service that is no longer provided on or after October 1, 2001, or any

new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(7) and (c)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) The RHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

8) Effective July 1, 2013, an RHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

d) Federally Qualified Health Centers
Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management;

B) laboratory services;

C) occupational therapy;

D) patient transportation;

E) pharmacy services;

F) physical therapy;

G) podiatric services;

H) optometric services;

I) speech and hearing services;

J) x-ray services;

K) health education;

L) nutrition services.

4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(7) and (d)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) The FQHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

8) Effective July 1, 2013, an FQHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

~~e) Maternal and Child Health Clinics~~
~~Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:~~

~~1) In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:~~

~~A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~

~~B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;~~

~~C) Regular immunizations for the prevention of childhood diseases;~~

~~D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;~~

~~E) Routine prenatal care, including risk assessment, for pregnant women; and~~

~~F) Specialty care as medically needed.~~

~~2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:~~

~~A) Prenatal care, including risk assessment (one risk assessment per pregnancy);~~

~~B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and~~

~~C) Services to pregnant women with diagnosed substance abuse or addiction problems.~~

~~3) In the case of clinics described in Section 140.461(f)(1)(D):~~

~~A) Comprehensive medical and referral services.~~

~~B) Primary care services, which must include, but are not necessarily limited to:~~

~~i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;~~

~~ii) regular immunizations for the prevention of childhood diseases; and~~

~~iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.~~

~~C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:~~

~~i) asthma,~~

~~ii) congenital heart disease,~~

~~iii)~~ ~~diabetes, and~~

~~iv)~~ ~~sickle cell anemia.~~

~~D)~~ ~~Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.~~

e~~f~~) School Based/Linked Health Clinics (Centers)
Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(f)~~(g)~~:

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments

a) Hospital-based organized clinics,~~Hospital-Based Organized Clinics~~ as described in Section 140.461(a), shall be paid in accordance with 89 Ill. Adm. Code 148.140.

~~1)~~ ~~With respect to those hospital-based organized clinics, as described at Section 140.461(a), that qualify as Maternal and Child Health clinics, as~~

~~described in Section 140.461(f)(1), payment shall be in accordance with Section 140.930.~~

~~2) With respect to all other hospital-based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.~~

b) Encounter Rate Clinics

1) For encounter rate clinics, as described at Section 140.461(b), providing comprehensive health care for infants and women, including but not limited to prenatal and postnatal care, payment shall be made at the lesser of:

A) $90 per encounter; or

B) The clinic's charge to the general public.

2) For encounter rate clinics, as described at Section 140.461(b), providing dental services, payment shall be made at the lesser of:

A) $85 per encounter; or

B) The clinic's historical annual cost per encounter as calculated for a Federally Qualified Health Center (FQHC) in accordance with Section 140.463(b)(3)(B).

3) For all other encounter rate clinics, payment shall be made at the lesser of:

A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

B) $50 per encounter; or

C) The clinic's charge to the general public.

c) County-Operated Outpatient Facilities

1) For critical clinic providers, as described in Section 140.461(h)(1), reimbursement for all services, including pharmacy-only-encounters, provided shall be on an all-inclusive per day encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.

2) For county ambulatory health centers, the final rate is determined as follows:

A) Base Rate. The base rate shall be the rate calculated as follows:

i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

ii) The resulting quotient, as calculated in subsection (c)(2)(A)(i), shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

iii) The resulting product, as calculated in subsection (c)(2)(A)(ii), shall be added to the resulting quotient, as calculated in subsection (c)(2)(A)(i), to determine the per encounter base rate.

iv) The resulting sum, as calculated in subsection (c)(2)(A)(iii), shall be the base rate.

B) Supplemental Rate

i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

iii) The quotient derived in subsection (c)(2)(B)(i) shall be added to the product derived in subsection (c)(2)(B)(ii) to determine the per encounter supplemental rate.

iv) The resulting sum, as described in subsection (c)(2)(B)(iii), shall be the supplemental rate.

C) Final Rate. The final rate shall be the sum of the base rate and the supplemental rate.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART G: MATERNAL AND CHILD HEALTH PROGRAM

Section 140.930 Reimbursement

a) Reimbursement Rates for Maternal and Child Health Providers

~~1) Participating providers described in Section 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.~~

1~~2~~) Participating FQHC~~FQHC's~~, as described in Section 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

2~~3~~) Participating encounter rate clinics shall be reimbursed in accordance with Section 140.464(b) for covered services provided to a Maternal and Child Health Program participant, as described in Section 140.922.

~~4) Participating Maternal and Child Health clinics, as described in Sections 140.924 and 140.461(f), will receive enhanced rates for certain medical~~

services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.

3~~5~~) Participating providers described in Section 140.924(a)(1) shall be eligible to receive a Well Child Visit Incentive Payment.

A) The provider will receive a one time annual payment of $30 for each qualifying child.

B) A qualifying child is a child who had its first, second, third, fourth or fifth birthday during the calendar year and for whom the provider personally, or through an affiliated provider, rendered all recommended well child visits, as described in Section 140.488.

C) Recommended services must be rendered during the 13-month period ending one month after the child's birthday. For children turning one year old, the period begins ten days after birth and ends one month after the child's birthday. Rendering of services will be based on Department claims data.

D) Payments~~The first incentive payments shall be made by June 30, 2007 for children who met the definition of a qualifying child during calendar year 2005. Subsequent payments~~ will be made at least annually.

E) For the purpose of payments under this Section, "affiliated provider" shall mean providers designated pursuant to Section 140.994.~~:~~

~~i) For qualifying children during calendar year 2005 through 2007, a provider with the same payee in accordance with Section 140.24(d).~~

~~ii) For qualifying children during calendar year 2008 and later, providers designated pursuant to Section 140.994.~~

b) Patient Management Fee
Providers who have accepted primary care responsibilities for foster children residing in Cook County who are under the guardianship of the Department of

Children and Family Services will receive a monthly patient management fee for each client enrolled with them.

c) Case Management Services
Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 140.TABLE J Rate Regions~~HSA Grouping (Repealed)~~

These geographic regions, comprised of counties, are used in various rate methodologies and are defined as follows:

Region 1 – Northwestern

Illinois Counties:

Boone	Bureau	Carroll	DeKalb	Fulton
Henderson	Henry	JoDaviess	Knox	LaSalle
Lee	Marshall	Mercer	Ogle	Peoria
Putnam	Rock Island	Stark	Stephenson	Tazewell
Warren	Whiteside	Winnebago	Woodford	

Out-of-State Counties:

Des Moines IA	Clinton IA	Dubuque IA	Johnson IA	Scott IA
Dane WI	Green WI	Rock WI	Grant WI	LaFayette WI
Jackson IA	Muscatine IA	Louisa IA		

Region 2 – Central

Illinois Counties:

Adams	Brown	Calhoun	Cass	Champaign
Christian	Clark	Coles	Cumberland	DeWitt
Douglas	Edgar	Ford	Greene	Hancock
Iroquois	Jersey	Livingston	Logan	Macon
Macoupin	Mason	McDonough	McLean	Menard
Montgomery	Morgan	Moultrie	Piatt	Pike
Sangamon	Schuyler	Scott	Shelby	Vermilion

Out-of-State Counties:

Marion IN	Vigo IN	Marion MO	Clark MO	Lewis MO
Ralls MO	Pike MO	Lincoln MO	Newton IN	Benton IN
Warren IN	Vermillion IN			

Region 3 – Southern

Illinois Counties:

Alexander	Bond	Clay	Clinton	Crawford
Edwards	Effingham	Fayette	Franklin	Gallatin
Hamilton	Hardin	Jackson	Jasper	Jefferson
Johnson	Lawrence	Madison	Marion	Massac
Monroe	Perry	Pope	Pulaski	Randolph
Richland	St. Clair	Saline	Union	Wabash
Washington	Wayne	White	Williamson	

Out-of-State Counties:

Vanderburgh IN	McCracken KY	Cape Girardeau MO	
St. Louis MO	City of St. Louis MO	St. Charles MO	Jefferson MO
Gibson IN	Ste. Genevieve MO	Perry MO	Scott MO
Mississippi MO	Posey KY	Livingston KY	Crittenden KY
Union KY	Sullivan IN	Knox IN	

Region 4 – Cook County

Cook

Region 5 – Collar Counties

Illinois Counties:

DuPage	Grundy	Kane	Kankakee	Kendall
Lake	McHenry	Will		

Out-of-State Counties:

Milwaukee County WI	Walworth WI	Kenosha WI	Lake IN

(Source: Old Table J repealed at 16 Ill. Reg. 19146, effective December 1, 1992; new Table J added at 38 Ill. Reg. _____, effective _____)

Section 140.TABLE M Enhanced Rates for Maternal and Child Health Provider Services (Repealed)

~~a) In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:~~

~~CODE~~	~~DESCRIPTION~~
~~W7359~~	~~Prenatal risk assessment~~
~~59409~~	~~Vaginal delivery~~
~~59410~~	~~Vaginal delivery~~
~~59500~~	~~C-section delivery~~
~~59514~~	~~C-section delivery~~
~~59515~~	~~C-section delivery~~

~~b) In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:~~

~~CODE~~	~~DESCRIPTION~~
~~W7018~~	~~Healthy kids screening-Chicago Downstate~~
~~W7360~~	~~Risk assessment, child referred for mental health assessment/services~~
~~W7361~~	~~Risk assessment, for mental health services, child, no referral~~
~~W7362~~	~~Risk assessment, for child referred for substance abuse assessment/treatment~~
~~W7363~~	~~Risk assessment for substance abuse, child, no referral~~
~~99201~~	~~Office visit – new patient – brief~~

~~99202~~	~~Office visit – new patient – limited~~
~~99203~~	~~Office visit – new patient – intermediate~~
~~99204~~	~~Office visit – new patient – extended~~
~~99205~~	~~Office visit – new patient – comprehensive~~
~~99211~~	~~Office visit – established patient – brief~~
~~99212~~	~~Office visit – established patient – limited~~
~~99213~~	~~Office visit – established patient – intermediate~~
~~99214~~	~~Office visit – established patient – extended~~
~~99215~~	~~Office visit – established patient – comprehensive~~

~~e)~~ ~~All other visits and services billed under valid CPT-4 procedure codes will be reimbursed at January 1, 1993, rates.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Specialized Health Care Delivery Systems

2) Code Citation: 89 Ill. Adm. Code 146

3)

Section Numbers:	Proposed Action:
146.100	Amend
146.105	Amend
146.110	Amend
146.115	Amend
146.125	Amend
146.130	Amend
146.840	Amend

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11

5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the SMART Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

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

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

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

9) Does this rulemaking contain incorporation by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes

Sections	Proposed Action	*Illinois Register* Citation
146.840	Amendment	37 Ill. Reg. 18005; November 15, 2013
146.410	Amendment	37 Ill. Reg. 18951; December 2, 2013
146.440	Amendment	378 Ill. Reg. 18951; December 2, 2013

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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., 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@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].

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 2014

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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

PART 146
SPECIALIZED HEALTH CARE DELIVERY SYSTEMS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section
146.100 General Description
146.105 Definitions
146.110 Participation Requirements
146.115 Records and Data Reporting Requirements
146.125 Covered Ambulatory Surgical Treatment Center Services
146.130 Reimbursement for Services

SUBPART B: SUPPORTIVE LIVING FACILITIES

Section
146.200 General Description
146.205 Definitions
146.210 Structural Requirements
146.215 SLF Participation Requirements
146.220 Resident Participation Requirements
146.225 Reimbursement for Medicaid Residents
146.230 Services
146.235 Staffing
146.240 Resident Contract
146.245 Assessment and Service Plan and Quarterly Evaluation
146.250 Resident Rights
146.255 Discharge
146.260 Grievance Procedure
146.265 Records and Reporting Requirements
146.270 Quality Assurance Plan
146.275 Monitoring
146.280 Non-Compliance Action
146.285 Voluntary Surrender of Certification
146.290 Geographic Groups

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

146.295 Emergency Contingency Plan
146.300 Waivers
146.305 Reporting of Suspected Abuse, Neglect and Financial Exploitation
146.310 Facility Management of Resident Funds

SUBPART C: STATE HEMOPHILIA PROGRAM

Section
146.400 Definitions
146.410 Patient Eligibility
146.420 Hemophilia Treatment Centers
146.430 Comprehensive Care Evaluation
146.440 Home Transfusion Arrangements
146.450 Obligations of the Department

SUBPART D: CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTERS

Section
146.500 General Description
146.510 Definitions
146.520 Participation Requirements
146.530 Records and Data Reporting Requirements
146.540 Covered Children's Community-Based Health Care Center Services
146.550 Reimbursement for Services
146.560 Individuals Eligible for Services Provided in a Children's Community-Based Health Care Center
146.570 Prior and Post Approval of Services

SUBPART E: SUPPORTIVE LIVING FACILITIES WITH DEMENTIA CARE UNITS

Section
146.600 General Description
146.610 Structural Requirements
146.620 Participation Requirements
146.630 Resident Participation Requirements
146.640 Services
146.650 Reimbursement for Medicaid Residents
146.660 Staffing
146.670 Assessment and Service Plan and Quarterly Evaluation

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

146.680 Monitoring
140.690 Reporting Requirements
146.700 Resident Rights
146.710 Discharge

SUBPART F: BIRTH CENTERS

146.800 General Description
146.810 Participation Requirements
146.820 Record Requirements
146.830 Covered Birth Center Services
146.840 Reimbursement of Birth Center Services

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

SOURCE: Old Part repealed at 14 Ill. Reg. 13800, effective August 15, 1990; new Part adopted at 20 Ill. Reg. 4419, effective February 29, 1996; emergency amendment at 21 Ill. Reg. 13875, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 4430, effective February 27, 1998; emergency amendment at 22 Ill. Reg. 13146, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19914, effective October 30, 1998; amended at 23 Ill. Reg. 5819, effective April 30, 1999; emergency amendment at 23 Ill. Reg. 8256, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13663, effective November 1, 1999; amended at 24 Ill. Reg. 8353, effective June 1, 2000; emergency amendment at 26 Ill. Reg. 14882, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 2176, effective February 1, 2003; emergency amendment at 27 Ill. Reg. 10854, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18671, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 12218, effective August 11, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 14214, effective October 18, 2004, for a maximum of 150 days; amended at 29 Ill. Reg. 852, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2014, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 4360, effective March 7, 2005; expedited correction at 29 Ill. Reg. 14127, effective March 7, 2005; amended at 29 Ill. Reg. 6967, effective May 1, 2005; amended at 29 Ill. Reg. 14987, effective September 30, 2005; amended at 30 Ill. Reg. 8845, effective May 1, 2006; amended at 31 Ill. Reg. 5589, effective April 1, 2007; emergency amendment at 31 Ill. Reg. 5876, effective April 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11681, effective August 1, 2007; amended at 33 Ill. Reg. 11803, effective August 1, 2009; emergency amendment at 36 Ill. Reg. 6751, effective April 13, 2012, for a maximum of 150 days; amended at 36 Ill. Reg. 13885, effective August 27, 2012; amended at 37 Ill. Reg. 17624, effective October 28, 2013; expedited

correction at 38 Ill. Reg. 4518, effective October 28, 2013; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

Section 146.100 General Description

This Part sets forth the conditions that an ambulatory surgical treatment center must meet in order to participate in the Medical Assistance~~Medicaid~~ Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.105 Definitions

For purposes of this Part, the following terms shall be defined as follows:

a) "Ambulatory Surgical Treatment Center" or "~~(~~ASTC~~).~~". Any distinct entity that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization. Such facilities shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-being of the patients or shall be transferred to a hospital or other similar environment. This provision shall include any place which meets the definition of an ambulatory surgical treatment center under the regulations of the Centers for Medicare and Medicaid Services~~Federal Health Care Financing Administration~~ (42 CFR 416). The term "ambulatory surgical treatment center" does not include:

1) Any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].~~;~~

2) Any person or institution required to be licensed pursuant to the Nursing Home Care Act [210 ILCS 45], the ID/DD Community Care Act [210 ILCS 47], or the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49].~~;~~

3) Hospitals or ambulatory surgical treatment centers maintained by the State or any department or agency thereof, where such department or agency

has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control.~~;~~

4) Hospitals or ambulatory surgical treatment centers maintained by the federal government or agencies thereof.~~; or~~

5) Any place, agency, clinic or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.

b) "Ambulatory Surgical Treatment Center Services." Facility services that are furnished in an ambulatory surgical treatment center.

c) "Department." The Illinois Department of Healthcare and Family Services ~~Public Aid~~.

d) "Facility Services." Services that are furnished in connection with covered surgical procedures performed in an ambulatory surgical treatment center.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.110 Participation Requirements

To participate in the Medical Assistance~~Medicaid~~ Program, an ambulatory surgical treatment center (ASTC) must, in addition to any other Department requirements:

a) Be licensed by the Illinois Department of Public Health pursuant to 77 Ill. Adm. Code 205.

b) In the case of an out-of-state ASTC, be licensed by the~~their~~ state in which it is located~~agency~~ or, where a state does not license ASTCs, be accredited by a national accrediting body.

c) Meet the requirements in 42 CFR 416.

d) Maintain a contractual relationship, including a transfer and referral plan with a hospital. Such a plan shall include procedures for effecting transfer of the patient from the ASTC to a hospital.

1) The contracting hospital must be within 15 minutes of the ASTC.

2) Have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the ASTC.

e) Ensure that a qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.

f) Must perform surgical procedures in a safe manner using qualified physicians or dentists who have been granted clinical privileges by the governing body of the ASTC. These providers must be licensed in the State of Illinois or, for an out-of-state ASTC, licensed by the state in which they practice and have skilled equivalent practice privileges at a licensed hospital.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.115 Records and Data Reporting Requirements

a) In addition to any other Department record requirements, the ambulatory surgical treatment center (ASTC) must maintain complete, comprehensive and accurate medical records to ensure adequate patient care that includes, but is not limited to, the following:

1) Patient identification.~~;~~

2) Significant medical history and results of physical examination.~~;~~

3) Preoperative diagnostic studies (entered before surgery), if performed.~~;~~

4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body of the ASTC or State~~state~~ law.~~;~~

5) Any known allergies and abnormal drug reactions.~~;~~

6) Entries related to anesthesia administration.~~;~~

7) Documentation of properly executed informed patient consent.~~;~~

8) Discharge diagnosis.~~; and~~

9) Medications ordered and administered.

b) ASTC medical records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each center visit.

c) Medical records for Medical Assistance~~Medicaid~~ patients must be made available to the Department or its designated representative in the performance of utilization review.

d) The ASTC agrees to furnish to the Department, if requested, information necessary to establish payment rates in the form and manner that the Department requires.

e) Services provided in an ASTC may be subject to prepayment and post-payment review to assess medical care, coding validation and quality of care.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.125 Covered Ambulatory Surgical Treatment Center Services

Effective for dates of service on or after July 1, 2014:

a) The Department of Healthcare and Family Services will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered enhanced ambulatory patient group (EAPG) services as defined in 89 Ill. Adm. Code 148.140(b)(1)~~Ambulatory Procedure Listing (APL) Groupings, as defined in 89 Ill. Adm. Code 148.140(b)(1)~~. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting.

b) Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:

1) Nursing, technician and related services.~~;~~

2) Use of the ASTC facilities.~~;~~

3) Supplies (such as drugs, biological products (e.g., blood)~~biologicals (for example, blood)~~), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures.~~;~~

4) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.~~;~~

5) Administrative, record keeping, and housekeeping items and services.~~; and~~

6) Materials for anesthesia.

c) Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' or dentists' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 146.130 Reimbursement for Services

Effective for dates of service on or after July 1, 2014:

a) With respect to all non-EAPG~~non-APL~~ procedures, reimbursement levels shall be at the lower of the ASTC's usual and customary charge to the public or the Department's Statewide maximum reimbursement screen.

b) With respect to EAPG~~APL~~ procedures described in 89 Ill. Adm. Code 148.140(b)(1), reimbursement for those ~~such~~ services shall be in accordance with~~an all-inclusive rate for facility services, and shall be calculated at 75 percent of the applicable group rate paid for that same procedure in a hospital outpatient setting, as described under~~ 89 Ill. Adm. Code 148.140(d)(7)~~(b)~~.

c) Laboratory, x-ray, prescription, physician ~~physicians'~~ or dental~~dentists'~~ services, provided in connection with a covered surgical procedure, must be billed by the

providers rendering those ~~such~~ services. If the ASTC provides the laboratory~~lab~~ or x-ray service, then:

1) Separate billing is NOT allowed if provided on the day of surgery; or

2) Separate billing IS allowed if provided on other than the day of surgery.

d) The providers described in subsection (c)~~ of this Section~~ must meet all applicable license, enrollment and reimbursement conditions of the Department of Healthcare and Family Services, the Department of Public Health and the Department of Financial and Professional Regulation-Division of Professional Regulation.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART F: BIRTH CENTERS

Section 146.840 Reimbursement of Birth Center Services

a) Facility services provided by a birth center located in Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

b) Facility services provided by a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

c) Observation services will be reimbursed at the lower of billed charges or at 75 percent of the rate established by the Department for the number of hours of observation billed pursuant to 89 Ill. Adm. Code 148.140(b)(1)(D) as reflected at http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx through dates of service on June 30, 2014. Effective for dates of service on or after July 1, 2014, observation services will be reimbursed at the lower of billed charges or $53.56 for 1 hour through 6.5 hours or more.

d~~e~~) Transfer fees for a birth center located in Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment

rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

e) Transfer fees for a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Services

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

3)

Section Numbers:	Proposed Action:
148.20	Amend
148.25	Amend
148.30	Amend
148.40	Amend
148.50	Amend
148.60	Amend
148.70	Amend
148.82	Amend
148.85	Repeal
148.90	Repeal
148.95	Repeal
148.100	Amend
148.103	Repeal
148.105	Amend
148.110	Amend
148.112	Amend
148.115	Amend
148.116	New
148.117	Amend
148.120	Amend
148.122	Amend
148.126	Amend
148.140	Amend
148.150	Amend
148.160	Amend
148.170	Amend
148.175	Repeal
148.180	Amend
148.200	Repeal
148.210	Amend
148.220	Repeal
148.230	Repeal
148.240	Amend
148.250	Repeal

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

148.260	Repeal
148.270	Repeal
148.280	Repeal
148.290	Amend
148.295	Amend
148.296	Amend
148.297	Amend
148.298	Repeal
148.300	Amend
148.310	Amend
148.320	Repeal
148.330	Amend
148.370	Amend
148.390	Amend
148.400	Amend
148.440	Amend
148.442	Amend
148.444	Amend
148.446	Amend
148.448	Amend
148.450	Amend
148.452	Amend
148.454	Amend
148.456	Amend
148.458	Amend
148.460	Repeal
148.462	Repeal
148.464	Amend
148.466	Amend
148.468	Amend
148.470	Amend
148.472	Amend
148.474	Amend
148.476	Amend
148.478	Amend
148.480	Amend
148.482	Amend
148.484	Amend
148.486	Amend

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

148.860	Amend
148.TABLE C	Amend

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11]

5) Complete Description of the Subjects and Issues Involved: This rulemaking is required pursuant to the SMART Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

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? Yes

Section	Proposed Action	*Illinois Register* Citation
148.436	New	37 Ill. Reg. 18011; November 15, 2013
148.600	Amend	37 Ill. Reg. 18959; December 2, 2013
148.610	Amend	37 Ill. Reg. 18959; December 2, 2013
148.630	Amend	37 Ill. Reg. 18959; December 2, 2013

11) Statement of Statewide Policy Objective: This rulemaking does affect units of local government. It will have an impact on government-owned or government-operated hospitals.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@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].

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 2014

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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

PART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS

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

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.85 Supplemental Tertiary Care Adjustment Payments (Repealed)
148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments (Repealed)
148.95 Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments (Repealed)
148.100 County Trauma Center~~Outpatient Rural Hospital~~ Adjustment Payments
148.103 Outpatient Service Adjustment Payments (Repealed)
148.105 Reimbursement Methodologies for Inpatient Rehabilitation Services~~Psychiatric Adjustment Payments~~
148.110 Reimbursement Methodologies for Inpatient Psychiatric Services~~Base Rate Adjustment Payments~~
148.112 Medicaid High Volume Adjustment Payments
148.115 Reimbursement Methodologies for Long Term Acute Care Services~~Rural Adjustment Payments~~
148.116 Reimbursement Methodologies for Children's Specialty Hospitals
148.117 Outpatient Assistance Adjustment Payments
148.120 Disproportionate Share Hospital (DSH) Adjustments
148.122 Medicaid Percentage Adjustments

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

148.126 Safety Net Adjustment Payments
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Public Law 103-66 Requirements
148.160 Payment Methodology for County-Owned Large Public Hospitals~~ in an Illinois County with a Population of Over Three Million~~
148.170 Payment Methodology for University-Owned Large Public Hospitals~~ Organized Under the University of Illinois Hospital Act~~
148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act (Repealed)
148.180 Payment for Pre-operative Days and~~,~~ Patient Specific Orders~~, and Services Which Can Be Performed in an Outpatient Setting~~
148.190 Copayments
148.200 Alternate Reimbursement Systems (Repealed)
148.210 Filing Cost Reports
148.220 Pre September 1, 1991, Admissions (Repealed)
148.230 Admissions Occurring on or after September 1, 1991 (Repealed)
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals (Repealed)
148.260 Calculation and Definitions of Inpatient Per Diem Rates (Repealed)
148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals (Repealed)
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Repealed)
148.285 Excellence in Academic Medicine Payments (Repealed)
148.290 Adjustments and Reductions to Total Payments
148.295 Critical Hospital Adjustment Payments~~ (CHAP)~~
148.296 Transitional Supplemental~~Tertiary Care Adjustment~~ Payments
148.297 Physician Development Incentive Payments~~Pediatric Outpatient Adjustment Payments~~
148.298 Pediatric Inpatient Adjustment Payments (Repealed)
148.300 Payment
148.310 Review Procedure
148.320 Alternatives (Repealed)
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

148.350 Definitions (Repealed)
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.368 Volume Adjustment (Repealed)
148.370 Payment for Sub-acute Alcoholism and Substance Abuse Treatment Services
148.380 Rate Appeals for Sub-acute Alcoholism and Substance Abuse Treatment Services (Repealed)
148.390 Hearings
148.400 Special Hospital Reporting Requirements
148.402 Medicaid Eligibility Payments (Repealed)
148.404 Medicaid High Volume Adjustment Payments (Repealed)
148.406 Intensive Care Adjustment Payments (Repealed)
148.408 Trauma Center Adjustment Payments (Repealed)
148.410 Psychiatric Rate Adjustment Payments (Repealed)
148.412 Rehabilitation Adjustment Payments (Repealed)
148.414 Supplemental Tertiary Care Adjustment Payments (Repealed)
148.416 Crossover Percentage Adjustment Payments (Repealed)
148.418 Long Term Acute Care Hospital Adjustment Payments (Repealed)
148.420 Obstetrical Care Adjustment Payments (Repealed)
148.422 Outpatient Access Payments (Repealed)
148.424 Outpatient Utilization Payments (Repealed)
148.426 Outpatient Complexity of Care Adjustment Payments (Repealed)
148.428 Rehabilitation Hospital Adjustment Payments (Repealed)
148.430 Perinatal Outpatient Adjustment Payments (Repealed)
148.432 Supplemental Psychiatric Adjustment Payments (Repealed)
148.434 Outpatient Community Access Adjustment Payments (Repealed)
148.440 High Volume Adjustment Payments
148.442 Inpatient Services Adjustment Payments
148.444 Capital Needs Payments
148.446 Obstetrical Care Payments
148.448 Trauma Care Payments
148.450 Supplemental Tertiary Care Payments
148.452 Crossover Care Payments
148.454 Magnet Hospital Payments
148.456 Ambulatory Procedure Listing Increase Payments
148.458 General Provisions
148.460 Catastrophic Relief Payments (Repealed)
148.462 Hospital Medicaid Stimulus Payments (Repealed)
148.464 General Provisions

148.466 Magnet and Perinatal Hospital Adjustment Payments
148.468 Trauma Level II Hospital Adjustment Payments
148.470 Dual Eligible Hospital Adjustment Payments
148.472 Medicaid Volume Hospital Adjustment Payments
148.474 Outpatient Service Adjustment Payments
148.476 Ambulatory Service Adjustment Payments
148.478 Specialty Hospital Adjustment Payments
148.480 ER Safety Net Payments
148.482 Physician Supplemental Adjustment Payments
148.484 Freestanding Children's Hospital Adjustment Payments
148.486 Freestanding Children's Hospital Outpatient Adjustment Payments

SUBPART C: SEXUAL ASSAULT EMERGENCY TREATMENT PROGRAM

Section
148.500 Definitions
148.510 Reimbursement

SUBPART D: STATE CHRONIC RENAL DISEASE PROGRAM

Section
148.600 Definitions
148.610 Scope of the Program
148.620 Assistance Level and Reimbursement
148.630 Criteria and Information Required to Establish Eligibility
148.640 Covered Services

SUBPART E: INSTITUTION FOR MENTAL DISEASES PROVISIONS FOR HOSPITALS

Section
148.700 General Provisions

SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section
148.800 General Provisions
148.810 Definitions
148.820 Individual Eligibility for the Program
148.830 Providers Participating in the Program
148.840 Stabilization and Discharge Practices

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

148.850 Medication Management
148.860 Community Connect IMD Hospital Payment
148.870 Community Connect TCM Agency Payment
148.880 Program Reporting

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

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

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150

days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083, effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency

amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; emergency expired June 7, 2004; amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February

24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; peremptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009; emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; amended at 35 Ill. Reg. 16572, effective October 1, 2011; emergency amendment at 36 Ill. Reg. 10326, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 148.70(g) suspended at 36 Ill. Reg. 13737, effective August 15, 2012; suspension withdrawn from Section 148.70(g) at 36 Ill. Reg. 18989, December 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 148.70(g) at 36 Ill. Reg. 18976, effective December 12, 2012 through June 30, 2013; emergency amendment to Section 148.140(b)(1)(F) suspended at 36 Ill. Reg. 13739, effective August 15, 2012; suspension withdrawn from Section 148.140(b)(1)(F) at 36 Ill. Reg. 14530, September 11, 2012; emergency amendment to Sections 148.140(b) and 148.190(a)(2) in response to Joint Committee on Administrative Rules action at 36 Ill. Reg. 14851, effective September 21, 2012 through June 30, 2013; amended at 37 Ill. Reg. 402, effective December 27, 2012; emergency rulemaking at 37 Ill. Reg. 5082, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10432, effective June 27, 2013; amended at 37 Ill. Reg. 17631, effective October 23, 2013; amended at 38 Ill. Reg. 4363, effective January 29, 2014; amended at 38 Ill. Reg. _____, effective _____.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

SUBPART A: GENERAL PROVISIONS

Section 148.20 Participation

Effective for dates of service on or after July 1, 2014:

a) Payment for hospital inpatient, outpatient and clinic services shall be made only when provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), for covered services, as described in Section 148.50.

~~b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992 through March 31, 1994 shall be as follows:~~

~~1) Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Sections: 148.130, 148.260, 148.270, and 148.280.~~

~~2) Exemptions. The provisions of subsection (b)(1) shall not apply to:~~

~~A) Hospitals reimbursed under Sections 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with Sections 148.82, 148.160, or 148.170, as applicable.~~

~~B) Hospitals reclassified as rural hospitals as described in Section 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with Section 148.40(f)(4) and Section 148.260 or 89 Ill. Adm. Code 149.100(c)(1)(A), whichever is applicable.~~

~~C) The inpatient payment adjustments described in Sections 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with Sections 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient~~

~~payment rate described in subsection (b)(1).~~

b)~~c)~~ Payment for freestanding emergency center services shall only be made when provided by a freestanding emergency center as defined in Section 148.25(e)~~148.25(h) of this Part~~.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.25 Definitions and Applicability

Effective for dates of service on or after July 1, 2014:

a) The term "large public hospital" means a hospital:

1) Owned by and located in an Illinois county with a population exceeding three million; or

2) Organized under the University of Illinois Hospital Act; or

3) Maintained by the Illinois Department of Human Services.~~Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.~~

b) The term "hospital" means:

1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, that:~~which~~

A) Is subject to licensure by the Illinois Department of Public Health (DPH) under the Hospital Licensing Act.

B) Is organized under the University of Illinois Hospital Act.

C) Is maintained by the State, or any department or agency of the State, when the department or agency has authority under the law to establish and enforce standards for the hospitalization or care facilities under its management and control.

D) Meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.~~is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:~~

~~A) County-owned hospitals, meaning all county-owned hospitals that are located in an Illinois county with a population of over 3 million.~~

~~B) A hospital organized under the University of Illinois Hospital Act.~~

~~C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.~~

2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1)~~of this Section~~, include~~an encounter rate hospital. An encounter rate hospital is defined as~~:

A) An ambulatory surgical treatment facility, as described in 89 Ill. Adm. Code 146.105(a). ~~An Illinois county-owned hospital located in a county with a population exceeding three million;~~

B) A free-standing emergency center, as described in subsection (e) of this Section. ~~hospital organized under the University of Illinois Hospital Act; or~~

~~C) A county-operated outpatient facility located in a county with a population exceeding three million that is also located in the State of Illinois.~~

3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean a county-operated outpatient facility owned by and located in an Illinois county with a population exceeding three million.~~:~~

~~A) A county-operated outpatient facility, as described in subsection (b)(2)(D) of this Section; or~~

~~B) A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B).~~

4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of Section 148.40(d) and 89 Ill. Adm. Code 140.461(a)~~ and Section 148.40(d)~~.

~~5) For the purpose of Maternal and Child Health reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Maternal and Child Health Managed Care Clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Maternal and Child Health Managed Care Clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:~~

~~A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);~~

~~B) Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);~~

~~C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and~~

~~D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).~~

~~6) For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition in subsection (b)(1) of this Section, mean the facilities operated by the Department of Human Services, including facilities that are accredited by the Joint Commission~~

~~on Accreditation of Health Organizations (JCAHO).~~

c) For the purpose of hospital inpatient reimbursement, the term "distinct part ~~hospital~~ unit" means a unit within a hospital, as defined in subsection (b)(1) ~~of this Section~~, that meets the following qualifications:

1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a ~~hospital, with a~~ functional ~~psychiatric~~ unit~~,~~ that is enrolled with the Department to provide inpatient psychiatric services (category of service 021).

2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a ~~hospital, with a~~ functional ~~rehabilitation~~ unit~~,~~ that is enrolled with the Department to provide inpatient rehabilitation services (category of service 022).

d) Specialty Hospitals ~~A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(c)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so classified.~~

1) Psychiatric Hospitals. To qualify as a psychiatric hospital, a facility must be:

A) Licensed by the state within which it is located as a psychiatric hospital and be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons.

B) Enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 021).

2) Rehabilitation Hospitals. To qualify as a rehabilitation hospital, a facility must be:

A) Licensed by the state within which it is located as a physical rehabilitation hospital.

B) Enrolled with the Department as a rehabilitation hospital to provide inpatient physical rehabilitation services (category of service 022).

3) Children's Hospitals. To qualify as a children's hospital, a facility must be devoted exclusively to caring for children and either be:

A) A hospital licensed by the state within which it is located as a pediatric, psychiatric or children's hospital.

B) A unit within a general hospital that was enrolled with the Department as a children's hospital on July 1, 2013. Units so enrolled shall be reimbursed for all inpatient and outpatient services provided to Medical Assistance enrollees who are under 18 years of age, with the exception of obstetric services, normal newborn nursery services, psychiatric services, and physical rehabilitation services, without regard to the physical location within the hospital where the care is rendered.

4) Long Term Acute Care Hospitals. To qualify as a long term acute care hospital, a facility must be licensed by the state within which it is located as an acute care hospital and certified by Medicare as a long term care hospital.

e) The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24-hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Freestanding Emergency Center Code (77 Ill. Adm. Code 518), as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] in effect for the jurisdiction in which it is located. ~~Except as provided in subsection (d) of this Section, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic~~

~~Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.~~

f) The term "coordinated care participating hospital" means a hospital, located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in Section 5-30 of the Illinois Public Aid Code (Code) that: ~~A non-teaching hospital is defined as:~~

1) Has entered into a contract to provide hospital services to enrollees of the care coordination program.~~A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or~~

2) Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly.~~A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.~~

g) The term "critical access hospital" means a hospital, located in Illinois, that has been designated as a critical care hospital by DPH in accordance with 42 CFR 485, Subpart F.~~Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:~~

~~1) "Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.~~

~~2) "Rate period" means:~~

~~A) For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the 18 month period beginning on October 1, 1992, and ending on March 31, 1994.~~

~~B) Beginning with admissions, or if applicable, dates of service, on or~~

~~after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.~~

~~3) "Rural hospital" means a hospital that is:~~

~~A) Located:~~

~~i) Outside a metropolitan statistical area; or~~

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

~~B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).~~

~~4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) of this Section.~~

h) Academic Medical Centers and Major Teaching Hospital Status. Hospitals dedicated to medical research and medical education shall be classified each State fiscal year in 3 tiers based on specific criteria:

1) Tier I. A private academic medical center must:

A) be a hospital located in Illinois that is:

i) under common ownership with the college of medicine of a non-public college or university; or

ii) a freestanding hospital in which the majority of the clinical chiefs of service or clinical department chairs are department chairs in an affiliated non-public Illinois medical school; or

iii) a children's hospital that is separately incorporated and non-integrated into the academic medical center hospital but is the pediatric partner for an academic medical center hospital and that serves as the primary teaching hospital for pediatrics for its affiliated Illinois medical school. A hospital identified in this subsection (h)(i)(A)(iii) is deemed to meet the additional Tier I criteria if its partner academic medical center hospital meets the Tier I criteria;

B) serve as the training site for at least 30 graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education;

C) facilitate the training on the campus or on affiliated off-campus sites of no less than 500 medical students, interns, residents and fellows during the calendar year preceding the beginning of the State fiscal year;

D) perform, either itself or through its affiliated university, at least $12,000,000 in medical research funded through grants or contracts from the National Institutes of Health or, with respect to hospitals described in subsection (h)(1)(A)(ii), have as its affiliated non-public Illinois medical school a medical school that performs, either itself or through its affiliated university, medical research funded using at least $12,000,000 in grants or contracts from the National Institutes of Health; and

E) expend, directly or indirectly, through an affiliated non-public medical school or as part of a hospital system, defined as a hospital and one or more other hospitals or hospital affiliates related by common control or ownership, no less than $5,000,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

2) Tier II. A public academic medical center must:

A) be a hospital located in Illinois that is a primary teaching hospital affiliated with:

i) University of Illinois School of Medicine at Chicago;

ii) University of Illinois School of Medicine at Peoria;

iii) University of Illinois School of Medicine at Rockford;

iv) University of Illinois School of Medicine at Urbana; or

v) Southern Illinois University School of Medicine in Springfield; and

B) contribute no less than $2,500,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

3) Tier III. A major teaching hospital must:

A) be an Illinois hospital with 100 or more interns and residents or with a ratio of interns and residents to beds greater than or equal to 0.25; and

B) support at least one graduate medical education program accredited by the Accreditation Council for Graduate Medical Education.~~The term "freestanding emergency center" means a facility that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located.~~

i) Children's Specialty Hospital. To qualify as a children's specialty hospital, a facility must be an Illinois hospital as defined in subsection (d)(3)(A) and have fewer than 50 total inpatient beds.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.30 General Requirements

Effective for dates of service on or after July 1, 2014:

a) For the purpose of hospital inpatient, hospital outpatient and hospital-based clinic reimbursement, the following requirements must be met by a hospital to qualify for enrollment in the Illinois Medical Assistance Program:

b)~~1)~~ The hospital must be certified for participation in the Medicare Program (Title XVIII) unless the provisions of subsection (c)~~(a)(2) of this Section~~ apply.

c)~~2)~~ If not eligible for or subject to Medicare certification, the hospital must be accredited by The~~the~~ Joint Commission (TJC)~~on the Accreditation of Healthcare Organizations (JCAHO)~~.

d)~~3)~~ The hospital must agree to accept the Department's basis for reimbursement.

~~b) Hospitals shall be required to file Medicaid and Medicare cost reports with the Office of Health Finance, Illinois Department of Public Aid, in accordance with Section 148.210, and shall have reimbursable hospital inpatient, outpatient and hospital-based clinic rates approved by the Department.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.40 Special Requirements

Effective for dates of service on or after July 1, 2014:

a) Inpatient Psychiatric Services

1) Payment for inpatient hospital psychiatric services shall be made only to:

A) A hospital that is a general hospital, as defined in Section

148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or

B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in Section 148.25(d)(1).~~89 Ill. Adm. Code 149.50(c)(1).~~

2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.

~~3) Inpatient psychiatric services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.~~

3)~~4)~~ Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his or ~~/~~her 21st birthday, ~~reimbursement for~~ psychiatric services shall be reimbursable by the Department~~shall be provided~~ until the earliest of the following:

A) The date the patient no longer requires the services.~~; or~~

B) The date the patient reaches 22 years of age.

4)~~5)~~ A psychiatric hospital must be accredited by TJC~~the Joint Commission on the Accreditation of Health Care Organizations~~ to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in ~~the State of~~ Illinois, or within ~~a~~ 100 miles~~mile radius of the State~~ of Illinois, must execute an ~~interagency~~ agreement with an Illinois~~a~~ Department of Human Services (DHS) operated mental health center (State-operated facility) for coordination of services including, but not limited to, crisis screening and

discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a)(5)~~(6) of this Section~~.

5)~~6)~~ Coordination of Care − Purpose. ~~In accordance with subsection (a)(5) of this Section, distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services.~~ The Coordination of Care Agreement shall set forth an agreement between the ~~DHS operated mental health center (~~State-operated facility~~)~~ and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

6)~~7)~~ Coordination of Care – General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a)(5)~~(6) of this Section~~ are as follows:

A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by TJC.~~JCAHO;~~

B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated under those Acts~~thereunder which~~ prohibit discrimination on the grounds of sex, race, color, national origin or handicap.~~;~~

C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 USCA 2000e, 29 USCA 203 et seq. and 775 ILCS 25.~~;~~

D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given 30 days prior notification.

7)~~8)~~ Coordination of Care – Special Requirements. The hospital shall:

A) Provide on its premises, the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care ~~and/~~or assessment of mental status, mental illness, emotional disability, and other psychiatric problems.~~;~~

B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission.~~;~~

C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission.~~;~~

D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process.~~;~~

E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital.~~; and~~

F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he or ~~/~~she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany

the recipient at the time of admission to the State-operated facility.

8)~~9)~~ Coordination of Care – Special Requirements of the State-Operated Facility. The State-operated facility shall:

A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.

B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.

C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.

9)~~10)~~ Coordination of Care – Special Requirements for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program. For individuals~~patients~~ under 21 years of age, all inpatient admissions must be authorized through the SASS Program. The hospital shall:

A) Prior to admission, contact the Crisis and Referral Entry Service (CARES), the Department's Statewide centralized intake and referral point for a mental health screening and assessment of the patient, pursuant to 59 Ill. Adm. Code 131.40;

B) For admissions authorized through a SASS screening, involve the SASS provider in the patient's treatment plan during the inpatient stay and in the development of a discharge plan in order to facilitate linkage to appropriate aftercare resources.

10)~~11)~~ A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period

of hospitalization is approved.

b) Inpatient Rehabilitation Services

1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in Section 148.25(d)(2)~~89 Ill. Adm. Code 149.50(c)(2)~~, which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.

2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

~~3) Inpatient rehabilitation services are not covered for Temporary Assistance for Needy Families (TANF) program participants who are 18 years of age or older.~~

3)~~4)~~ For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified ~~by the Health Care Financing Administration~~ for participation under the Medicare Program ~~(Title XVIII)~~ and must be licensed and/or certified by ~~the Department of Public Health (~~DPH~~)~~ to provide comprehensive physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.

4)~~5)~~ A rehabilitation facility must meet the following criteria:

A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation.~~;~~

B) Have an organized medical staff.~~;~~

C) Have available consultants qualified to perform services in appropriate specialties.~~;~~

D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services.~~;~~

E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results.~~; and~~

F) Submit reports as required by the Department~~ of Healthcare and Family Services (HFS)~~.

5)~~6)~~ A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:

A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing.~~;~~

B) Full-time physical therapy and occupational therapy services.~~; and~~

C) Social casework services as an integral part of the rehabilitation program.

6)~~7)~~ A rehabilitation facility must have available the following minimal services:

A) Psychological evaluation services.~~;~~

B) Prosthetic and orthotic services.~~;~~

C) Vocational counseling.~~;~~

D) Speech therapy.~~;~~

E) Clinical laboratory and x-ray services.~~; and~~

F) Pharmacy services.

7)~~8)~~ The director of rehabilitation must meet the following criteria:

A) Provide services to the hospital and its patients as specified in subsection (b)(4).~~(5) of this Section;~~

B) Be a doctor of medicine or osteopathy.~~;~~

C) Be licensed under State law to practice medicine or surgery.~~; and~~

D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

8)~~9)~~ Personnel of the rehabilitation facility must meet the following minimum standards:

A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.

B) Physical therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.

C) Occupational therapists shall be licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state in which the facility is located.

D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Financial and Professional Regulation or comparable licensing agency in the state~~State~~ in which the facility is located.

E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.

F) Psychologists shall have a Master's Degree in clinical psychology.

G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.

H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.

c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:

1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease.~~;~~

2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (2013~~1994~~).~~; or~~

3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subpart U (2013~~1994~~).

d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following two categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:

1) Psychiatric Clinic Services

A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic

services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting.

B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any 12 month period.

~~C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for TANF participants who are 18 years of age or older.~~

C)~~D)~~ Approval. The Department and DHS~~Department of Human Services and HFS~~ are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must have previously been enrolled with the Department for the provision of inpatient psychiatric services on or after June 1, 2002 or must be currently enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DHS and the Department~~HFS~~, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:

i) The hospital must be accredited by, and be in good standing with, TJC.~~the Joint Commission on Accreditation of Health Care Organizations (JCAHO);~~

ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated DHS State-operated facility serving the mentally ill in the appropriate geographic area.~~;~~

iii) The clinical staff of the psychiatric clinic must collaborate

with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services.~~;~~

~~iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and~~

iv)~~v)~~ The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by the Department~~HFS~~.

D)~~E)~~ Duration of Approval. The approval described in subsection (d)(1)(D) of this Section shall be in effect for a period of two years from the date HFS approves the psychiatric clinic's enrollment. The approval may be terminated by HFS or DHS with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to HFS and DHS when terminating delivery of psychiatric clinic services.

2) Physical Rehabilitation Clinic Services

~~A)~~Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

~~B) Physical rehabilitation clinic services are not covered for TANF participants who are 18 years of age or older.~~

~~e) Maternal and Child Health Clinics. Maternal and Child Health Clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).~~

~~f) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS) (see 89 Ill. Adm. Code 149)~~

~~1) Effective with admissions occurring on or after September 1, 1991, and~~

~~before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~

~~2)~~ ~~Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act [20 ILCS 2215] and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.~~

~~3)~~ ~~In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):~~

~~A)~~ ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, or~~

~~B)~~ ~~the rate calculated under Section 148.260.~~

~~4)~~ ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):~~

~~A)~~ ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or~~

~~B)~~ ~~the rate calculated under Section 148.260 that would have been in~~

~~effect for the rate period described in Section 148.25(g)(2)(A) if the hospital had been designated as a sole community hospital on October 1, 1992.~~

~~5)~~ ~~For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):~~

~~A)~~ ~~the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or~~

~~B)~~ ~~the rate calculated under Section 148.260.~~

~~g)~~ ~~Annual Irrevocable Election~~

~~1)~~ ~~Hospitals described in subsections (f)(2) and (f)(3) of this Section may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) at the beginning of each rate period.~~

~~2)~~ ~~Hospitals described in subsection (f)(4) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(4) effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).~~

~~3)~~ ~~Hospitals described in subsection (f)(5) of this Section may elect to be reimbursed under the special arrangements described in subsection (f)(5) at the beginning of each rate period described in Section 148.25(g)(2)(B).~~

~~4)~~ ~~Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.~~

~~5)~~ ~~Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.~~

~~Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.~~

~~6)~~ ~~Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.~~

~~h)~~ ~~Notification of Reimbursement Methodology~~

~~1)~~ ~~Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.~~

~~2)~~ ~~Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) of this Section shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) shall have 30 days after the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within 30 days after the date of notification, as described in this Section, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) of this Section.~~

e)~~i)~~ Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an individual enrolled in any of the Medical Assistance Programs administered by the Department~~Illinois Medicaid eligible person~~, including newborns, regardless of payer~~payor~~. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information may~~can~~ be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.50 Covered Hospital Services

Effective for dates of service on or after July 1, 2014:

a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and clinic diagnostic and treatment services not otherwise excluded or limited that~~which~~ are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and that~~which~~ are provided in compliance with hospital licensing standards. Payment may be made for the following types of care subject to the special requirements described in Section 148.40:

1) General/specialty services.~~;~~

2) Psychiatric services.~~;~~

3) Rehabilitation services.~~; and~~

4) End-Stage Renal Disease Treatment (ESRDT) services.

b) Certain services~~programs~~ are defined~~administered~~ as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.

c) Hospital Residing Long Term Care Services

1) Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is

enrolled with the Department to provide hospital residing long term care:

A) A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or

B) A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.

2) There are three categories of service for hospital residing long term care. These categories are as follows:

A) Skilled Care – Hospital Residing (category of service 037) Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

i) The hospital must document its attempt to place the patient in at least five appropriate facilities.

ii) Documentation (form HFS 3127~~DPA 3127~~) must be attached to the appropriate claim form and submitted to the Department.

iii) Reimbursement is limited to services provided after the minimum number of contacts has~~have~~ been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may~~will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

B) Exceptional Care – Hospital Residing (category of service 038) Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely

performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for the~~such~~ reimbursement, the following criteria must be met:

i) The hospital~~hospial~~ must document its attempt to place the patient in at least five appropriate facilities.

ii) Documentation (form HFS 3127~~DPA 3127~~) must be attached to the appropriate claim form and submitted to the Department.

iii) Reimbursement is limited to services provided after the minimum number of contacts has~~have~~ been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may~~will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

C) ID~~DD~~/MI Non-Acute Care – Hospital Residing (category of service 039)
Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide ~~DD/MI~~ rate for intermediate care facilities for persons with intellectual disabilities. For a hospital to be eligible for such

reimbursement, the following criteria must be met:

i) The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.

ii) Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.

d) Subacute Alcoholism and Substance Abuse Treatment Services
~~1)Subacute alcoholism and other substance abuse treatment is a covered service for clients under Title XIX (Medicaid) and for children 13 to or through 18 years of age in Family and Children Assistance cases in the City of Chicago. 2)Only acute alcoholism and substance abuse treatment services (detoxification) are covered as hospital services.~~ Rules~~Regulations~~ regarding reimbursement for sub-acute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.

e) Transplant Program
The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. ~~Payment for kidney and cornea transplants is made in accordance with the appropriate methodology described in Sections 148.160, 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149.100 and 149.150. Kidney acquisition costs shall be reimbursed in accordance with 89 Ill. Adm. Code 149.150(c)(5). Payment for bone marrow, heart, liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered and reimbursed in accordance with Section 148.82 provided the hospital is certified by the Department to perform the transplant.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.60 Services Not Covered as Hospital Services

Effective for dates of service on or after July 1, 2014, certain~~Certain~~ services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital

setting or by an entity associated with the hospital, are not reimbursed by the Department as hospital services. In addition, certain services currently provided in the hospital outpatient and hospital-based clinic setting are subject to fee-for-service payment methodologies. This means that for these services, hospitals shall be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services shall be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting. Services not covered or reimbursed as hospital services are as follows:

a) Private Duty Nursing Services. Private duty nursing services for hospitalized program participants are not covered under the Medical Assistance Program. Hospitals are expected to provide all required nursing services.

b) Sitter Services. Sitter services for hospitalized program participants are not covered under the Medical Assistance Program.

c) Dental Services. Hospitals may not enroll to provide dental services. When dental services are provided in the outpatient/clinic setting of a hospital, the dentist shall submit charges to the Department according to the provisions of the Dental Program.

d) Nurse Anesthetist Services. Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program ~~(Social Security Act, Title XVIII)~~ and shall be made to such hospitals when provided by a hospital employed non-physician anesthetist (certified registered nurse anesthetist~~Certified Registered Nurse Anesthetist~~ or "CRNA").

e) Pharmacy Services. Policy and reimbursement for pharmacy services are described in 89 Ill. Adm. Code 140.440 through 140.450. A hospital pharmacy may enroll on a fee-for-service basis for services provided to a patient in:

1) A specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program.~~;~~

2) A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility.~~; or~~

3) The outpatient/clinic setting when the services provided are not unique to the hospital setting.

f) Medical Transportation Services. A hospital that owns and operates medical transportation vehicles as a separate entity (for example, a private corporation) must enroll as a medical transportation provider. A hospital that owns and operates medical transportation vehicles that are included on the hospital's cost report as a cost center of the hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients. Policy and reimbursements for medical transportation services is described in 89 Ill. Adm. Code 140.490 through 140.492.

g) Home Health Services. ~~Home health services are not considered by the Department to be hospital services.~~ A home health agency that is administratively associated with a hospital and that is certified for participation as a home health agency by the Medicare Program may apply for participation for the provision of home health services. Policy and reimbursement for home health services is described in 89 Ill. Adm. Code 140.470 through 140.474.

h) Sub-acute Alcoholism and Substance Abuse Treatment Services. Only acute alcoholism and substance abuse treatment services (i.e., detoxification) are covered as hospital services. Rules~~Regulations~~ regarding reimbursement for sub-acute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.

i) Hospice Services. Hospice is an alternative to traditional Medicaid coverage. The Hospice Program is responsible for all the client's medical needs related to a terminal illness. If a client chooses the Hospice Program, a physician must certify that the client is terminally ill and has a life expectancy of six months or less. Policy and reimbursement for hospice services is described in 89 Ill. Adm. Code 140.469.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.70 Limitation On Hospital Services

Effective for dates of service on or after July 1, 2014:

a) Payment for inpatient hospital care in general and specialty hospitals, including psychiatric hospitals, shall be made only when it is recommended by a qualified physician, and the care is essential as determined by the appropriate utilization

review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.105 through 148.115 and 148.160 through 148.170~~ and 148.250 through 148.300~~, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.

b) For hospitals ~~or distinct part units~~ reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code ~~Part~~ 149.

c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.105 through 148.115 and 148.160 through 148.170~~ and 148.250 through 148.300~~, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.

~~d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.~~

d)~~e)~~ Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 148.25(d)(1)~~89 Ill. Adm. Code 149.50(c)(1)~~, shall be made only when such services have been provided in accordance with federal regulations at 42 CFR 441, subparts C and D.

e)~~f)~~ Payment for transplantation costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82. Payment for kidney and cornea transplantation costs does not require enrollment as an approved transplantation center~~ and is only provided to hospitals reimbursed on a per case basis in accordance with 89 Ill. Adm. Code 149~~.

f)~~g)~~ The~~Effective with inpatient hospital admissions on or after July 1, 2012, the~~

Department shall reduce the payment for a claim that indicates the occurrence of a provider preventable condition during the admission as specified in this subsection (fg).

1) Until such time as the All Patient Refined Diagnosis Related Groups (APR-DRG) is implemented by the Department in rule, as authorized by Section 14-11 of the Public Aid Code, the Department shall reduce each claim that indicates the occurrence of a health care acquired condition (HAC) by $900.

1)2) TheAfter the APR-DRG is implemented by the Department in rule, as authorized by Section 14-11 of the Public Aid Code, the Department shall reduce each claim by the amount that the payment on the claim is increased directly due to the occurrence of and treatment for a healthcare acquired conditionthe (HAC).

2)3) The Department shall not pay for services related to Other Provider Preventable Conditions (OPPCs).

3)4) For HACs, hospitals shall code inpatient claims with a Present on Admission (POA) indicator for principal and secondary diagnosis codes billed. For OPPCs, hospitals shall submit claims to report these incidents and will be instructed to populate the inpatient claims with specific supplementary diagnosis coding.

4)5) Definitions. As used in this subsection (fg), the following terms are defined as follows:

"Provider Preventable Condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 (2012) or an Other Provider Preventable Condition.

"Other Provider Preventable Condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

h) Payment for caesarean sections shall be at the normal vaginal delivery rate unless a caesarean section is medically necessary.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.82 Organ Transplant Services

Effective for dates of service on or after July 1, 2014:

a) Introduction
The Department ~~of Public Aid~~ will cover organ transplants as identified under subsection (b) ~~of this Section~~ that are provided to United States citizens or aliens who are lawfully admitted for permanent residence in the United States under color of law pursuant to 42 USC 1396a(a) and 1396b(v). These~~Such~~ services must be provided by certified organ transplant centers that~~which~~ meet the requirements specified in subsections (c) through (g~~h~~) of this Section.

b) Covered Services

1) Inpatient heart, heart/lung, lung (single or double), liver, pancreas or kidney/pancreas transplantation. Inpatient bone marrow transplants, inpatient and outpatient stem cell transplants.

2) Inpatient intestinal (small bowel or liver/small bowel) transplantation for children only (see subsection (d)(1)(H) of this Section).

3) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in subsection (c) ~~of this Section~~ and provide the necessary documentation of the number of transplant procedures performed and the survival rates.

4) Medically necessary work-up.

c) Certification Process

1) In order to be certified to receive reimbursement for transplants performed on Medical Assistance ~~and KidCare~~ patients, the hospital must:

A) Request an application from the Bureau of Comprehensive Health Services.~~;~~

B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification.~~;~~

C) Meet certification criteria established in subsection (d). ~~of this Section, based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and~~

D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. The~~Such~~ reports must include the patient's diagnosis, date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed in the time frames required for the type of transplant indicated in subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) ~~of this Section~~. To protect the privacy of patients included in this report, names of patients who are not covered under Medical Assistance ~~or KidCare~~ are not required.

2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medical Assistance ~~and KidCare~~ eligible patients.

3) In the event the Department receives a request for prior approval to provide a service from a hospital not formally certified under this Section, the Department may approve the request if it determines that circumstances are such that the health, safety and welfare of the recipient would best be served by receiving the service at that hospital. In making its determination, the Department shall take into account the ability and qualifications of the hospital ~~hospital's~~ and its medical staff~~staff's ability and qualifications~~ to provide the service, the burden on the recipient's family if a certified hospital is a great distance from their home, and the urgent nature of the transplant.

4) A joint application combining the statistical data for the adult and

pediatric programs from two affiliated hospitals that share the same surgeons may be submitted for review. ~~by the State Medical Advisory Committee.~~ The hospitals must meet the criteria under subsections (d)(1)(A), (B), (K), (L), (M), (N), (O), (P) and (Q), the applicable criteria under subsections (d)(1)(C), (D) or (J) and (d)(1)(R), subsections (d)(2), (3) and (4), and subsection (e) ~~of this Section~~ for certification and recertification.

d) Certification Criteria

1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:

A) The hospital is capable of providing all necessary medical care required by the transplant patient.~~;~~

B) The hospital is affiliated with an academic health center.~~;~~

C) The hospital has had the transplant program for inpatient adult heart and liver transplants in operation for at least three years with 12 transplant procedures per year for the past two years and 12 cases in the three-year period preceding the most current two-year period for adult heart and liver transplants.~~;~~

D) The hospital has had the transplant program for inpatient adult heart/lung and lung transplants in operation for at least three years with ten transplant procedures per year for the past two years and 10~~ten~~ cases in the three-year period preceding the most current two-year period for adult heart/lung and lung transplants.~~;~~

E) A hospital specializing in inpatient pediatric heart/lung and lung transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.~~;~~

F) The hospital has had the transplant program for inpatient adult and pediatric bone marrow transplants in operation for at least two years with 12 transplant procedures per year for the past two

years.~~;~~

G) The hospital performing outpatient adult and pediatric stem cell transplants must be part of a certified inpatient program and must have been in operation for at least two years with at least 12 outpatient stem cell transplant procedures per year in the past two years.~~;~~

H) A hospital specializing in inpatient pediatric heart or liver transplants, or both, has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.~~;~~

I) A hospital specializing in inpatient pediatric intestinal (small bowel or liver/small bowel) transplants has had a program in operation for at least three years and has performed a minimum of six transplant procedures per year for the past two years, and six procedures in the three-year period preceding the most current two-year period.~~;~~

J) A hospital specializing in inpatient kidney/pancreas and/or pancreas transplants has had the transplant program in operation for at least three years with 25 kidney transplant procedures per year for the past two years and 25 cases in the three-year period preceding the most current two-year period, and five pancreas transplant procedures per year for the past two years and five in the three year period preceding the most current two-year period, or 12 kidney/pancreas transplant procedures per year for the past two years and 12 in the three-year period preceding the most current two-year period.~~;~~

K) The hospital has experts, on staff, in the fields of cardiology, pulmonology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant center for pediatric patients, the hospital must also have experts in the field of pediatrics.~~;~~

L) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart and heart/lung transplant candidates.~~;~~

M) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation as supported by appropriate documentation.~~;~~

N) The hospital complies with applicable State and federal laws and regulations.~~;~~

O) The hospital participates in a recognized national donor procurement program for organs or bone marrow provided by unrelated donors, abides by its rules, and provides the Department with the name of the national organization of which it is a member.~~;~~

P) The hospital has an interdisciplinary body to determine the suitability of candidates for transplantation as supported by appropriate documentation.~~;~~

Q) The hospital has blood bank support necessary to meet the demands of a certified transplant center as supported by appropriate documentation.~~; and~~

R) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department:

i) A one-year survival rate of 50 percent for inpatient bone marrow and inpatient and outpatient stem cell transplant patients.~~;~~

ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients.~~;~~

iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients.~~;~~

iv) A one-year survival rate of 90 percent for kidney transplant and a one-year survival rate of 80 percent for pancreas transplant; or a one-year survival rate of 80 percent for kidney/pancreas transplant.~~;~~

v) A one-year survival rate of 65 percent and a two-year survival rate of 60 percent for heart/lung and lung (single or double) transplant patient.~~;~~

vi) A one-year survival rate of 60 percent and a two-year survival rate of 55 percent for intestinal transplants (small bowel or liver/small bowel).

2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must submit appropriate documentation to demonstrate that:

A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility.~~;~~

B) The hospital safeguards the rights and privacy of patients.~~;~~

C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.

3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.

4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.

e) Recertification Process/Criteria

1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and (g)~~(h) of this Section for review by the Department's State Medical Advisory Committee~~ for recertification as a transplant center.

2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.

3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.

4) If the hospital has previously met the requirements for certification or recertification of its program under subsections (d)(1)(K), ~~(K),~~ (L), (M), (N), (O), (P) and (Q) and (d)(2), (3) and (4) ~~of this Section~~ and the program has experienced no changes under the above subsections, as evidenced in written documentation on the hospital's application, the hospital will not be required to resubmit the same data.

5) If a center has previously met the requirements for certification or recertification of its program under subsections (d)(1) (K), (L), (M), (N), (O), (P), (Q) and (R)(i) through (R)(vi), but has performed fewer than the required number of transplants pursuant to subsections (d)(1)(C), (D), (E), (F), (G), (H), (I) or (J) as appropriate, the Department may recertify the center if it determines that the best interests of the Medical Assistance ~~or KidCare~~ client eligible for transplant services would be served by allowing continued certification of the center. Criteria the Department may consider in making such a determination include, but are not limited to:

A) Not recertifying a center would limit the accessibility of available organs.

B) Other centers are not accepting new patients or have extensive waiting lists.

C) The distance to other eligible centers would jeopardize the client's opportunity to receive a viable organ/tissue transplant.

f) Notification of Transplant

1) The hospital must notify the Department prior to performance of the transplant procedure. The notification letter must be from a physician on the transplant team.

2) The notification must include the admission diagnosis and pre-transplant diagnosis.

3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate outcome summary forms to the hospital.

~~g) Reimbursement~~

~~1) Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.250 through 148.330 and 89 Ill. Adm. Code 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for a maximum number of days listed below for specific types of transplants:~~

~~A) 30 consecutive days of post-operative inpatient care for heart, heart/lung, lung (single or double), pancreas, or kidney/pancreas transplant; or~~

~~B) 40 consecutive days of post-operative inpatient care for liver transplant; or~~

~~C) 50 consecutive days of post-operative inpatient care for bone marrow transplant (this includes a maximum of seven days prior to the transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant; or~~

~~D) 70 consecutive days of post-operative inpatient care for intestinal~~

~~(small bowel or liver/small bowel) transplants; or~~

~~E) For those transplants covered under subsection (b)(2) of this Section, the number of consecutive days of inpatient care specified within the transplant certification process.~~

~~2) Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim. Reimbursement will not be made until the discharge summary has been submitted to the Department.~~

~~3) Applicable disproportionate share payment adjustments shall be made in accordance with Section 148.120(g). Applicable outlier adjustments shall be made in accordance with Section 148.130. Applicable Medicaid High Volume adjustments shall be made in accordance with Section 148.290(d).~~

~~4) The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 140.490 through 140.492, respectively.~~

~~5) Hospital reimbursement for bone marrow searches is limited to 60 percent of charges up to a maximum of $25,000. Payment for bone marrow searches will only be made to the certified center requesting reimbursement for the bone marrow transplant.~~

~~6) Reimbursement for stem cell acquisition charges which includes the mobilization, chemotherapy, cytokines and apheresis processes must be billed under the appropriate revenue code on the claim submitted for the transplant procedure.~~

g)~~h)~~ Reporting Requirements of Certified Transplant Center
The following documentation must be submitted within the time limits set forth in this subsection (g~~h~~).

1) Outcome Summary

A) The discharge summary for each Medical Assistance ~~and KidCare~~ patient must be received by the Department within 30 days after the patient's discharge.

B) For those Medical Assistance ~~and KidCare~~ patients who expire, a summary must be received by the Department within 30 days after the patient's death.

2) Notification of Changes
The center must notify the Department within 30 days after any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.85 Supplemental Tertiary Care Adjustment Payments (Repealed)

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

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

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

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

~~b) Supplemental Tertiary Care Adjustment Payments~~

~~1) For the supplemental tertiary care adjustment period occurring in State fiscal year 2004, total payments will equal the State fiscal year 2003 tertiary care adjustment payment, as defined in Section 148.296, multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (d) of this Section have been met.~~

~~2) For the supplemental tertiary care adjustment period occurring in State fiscal year 2005, total payments will equal the State fiscal year 2003~~

~~tertiary care adjustment payment, as defined in Section 148.296 and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (d) being met, shall be paid within 75 days after the conditions described in subsection (d) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~e) Definitions~~

~~1) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

~~2) "Supplemental Tertiary Care Adjustment Period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the 12-month period beginning July 1 of the year and ending June 30 of the following year.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.90 Medicaid Inpatient Utilization Rate (MIUR) Adjustment Payments (Repealed)

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

~~b) MIUR Adjustment Payments~~

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

~~A) The quotient of:~~

~~i) $57.25~~

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

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

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

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

~~c) Payment to a Qualifying Hospital~~

~~1) For the MIUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~

~~2) For the MIUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~d) Definitions~~

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

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

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

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

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

~~6) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

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

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

~~b) MOUR Adjustment Payments~~

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

~~A) The quotient of:~~

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

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

~~B) 2.45 percent.~~

~~2) For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment~~

~~described in subsection (b)(1) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

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

~~c) Payment to a Qualifying Hospital~~

~~1) For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~

~~2) For the MOUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~d) Definitions~~

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

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

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

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

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

~~6) "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

~~7) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.100 County Trauma Center~~Outpatient Rural Hospital~~ Adjustment Payments

Effective for dates of service on or after July 1, 2014:

a) County Trauma Center Adjustment (TCA) Payments. Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by DPH, shall receive an adjustment that shall be calculated as follows: ~~Qualifying Criteria. Outpatient Rural Hospital Adjustment Payments, as described in subsection (b) of this Section, shall be made to qualifying Illinois rural hospitals, as described in Section 148.25(g)(3), excluding:~~

1) The available funds from the Trauma Center Fund each quarter shall be divided by the number of each eligible hospital's (as defined in subsection (a)(4)) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter. ~~County-owned hospitals as described in Section 148.25(b)(1)(A).~~

2) The TCA payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Illinois Public Aid Code. ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~

3) The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis. ~~A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~

4) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by DPH, or the appropriate licensing agency, as a Level I or Level II trauma center as required for the adjustments described in subsection (a)(1). In these instances, the adjustments calculated under this subsection (a)(4) shall be pro-rated as applicable, based upon the date that recognition ceased.

b) Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments in this Section are as follows: ~~Outpatient Rural Hospital Adjustment Payments~~

1) "Available funds" means funds that have been deposited into the Trauma Center Fund, have been distributed to the Department by the State Treasurer, and have been appropriated by the Illinois General Assembly. ~~Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.~~

2) "Medicaid trauma admission" means for, discharges through June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions, excluding admissions for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: ~~This ratio will be multiplied by $14,500,000 to determine the hospital's Outpatient Rural Hospital Adjustment Payment.~~

800.0 through 800.99; 801.0 through 801.99; 802.0 through 802.99; 803.0 through 803.99; 804.0 through 804.99; 805.0 through 805.98; 806.0 through 806.99; 807.0 through 807.69; 808.0 through 808.9; 809.0 through 809.1; 828.0 through 828.1; 839.0 through 839.3; 839.7 through 839.9; 850.0 through 850.9; 851.0 through 851.99; 852.0 through 852.59; 853.0 through 853.19; 854.0 through 854.19; 860.0 through 860.5; 861.0 through 861.32; 862.8; 863.0 through 863.99; 864.0 through 864.19; 865.0 through 865.19; 866.0 through 866.13; 867.0 through 867.9; 868.0

through 868.19; 869.0 through 869.1; 887.0 through 887.7; 896.0 through 896.3; 897.0 through 897.7; 900.0 through 900.9; 902.0 through 904.9; 925; 926.8; 929.0 through 929.99; 958.4; 958.5; 990 through 994.99.

For discharges after June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, and have been grouped to one of the following DRGs:

020 Craniotomy for trauma.

055 Head trauma, with coma lasting more than one hour or hemorrhage.

056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.

057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

135 Major chest and respiratory trauma.

308 Hip and femur procedures for trauma, except joint replacement.

384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

910 Craniotomy for multiple significant trauma.

911 Extensive abdominal/thoracic procedures for multiple significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

3) "TCA base period" means the 12-month period ending on the last day of June preceding the TCA rate period. ~~For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in subsection (b)(2) of this Section shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

4) "TCA rate period" means the 12-month period beginning on October 1 of the year and ending September 30 of the following year.

5) "Trauma Center Fund" means the fund created in the State treasury by Section 5.325 of the State Finance Act [30 ILCS 105] and described in Section 3.225 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and Section 5-5.03 of the Public Aid Code.

~~c) Payment to a Qualifying Hospital~~

~~1) For the outpatient rural hospital adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (e) of this Section have been met.~~

~~2) For the outpatient rural hospital adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (e) being met, shall be paid within 75 days after the conditions described in subsection (e) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~d) Definitions~~

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

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

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

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

~~5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.103 Outpatient Service Adjustment Payments (Repealed)

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

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

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

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

~~b) Outpatient Service Adjustment Payments~~

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

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

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

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

~~c) Payment to a Qualifying Hospital~~

~~1) For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions in subsection (e) of this Section have been met.~~

~~2) For the outpatient service adjustment period occurring in State fiscal year 2005, total annual payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (e) being met, shall be paid within 75 days after the conditions in subsection (e) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~d) Definitions~~

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

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

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

~~4) "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 148.140(b), excluding~~

services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.

5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.

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

1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;

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

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

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.105 Reimbursement Methodologies for Inpatient Rehabilitation ServicesPsychiatric Adjustment Payments

Effective for dates of service on or after July 1, 2014:

a) Inpatient rehabilitation services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS.
Qualifying Criteria
Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

1) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric

~~distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.~~

~~2)~~ ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.~~

~~3)~~ ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.~~

~~4)~~ ~~The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.~~

~~5) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the Statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has 50 or more total licensed psychiatric beds as described in subsection (e)(3) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 60 percent.~~

b) Inpatient rehabilitation services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsection (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:

1) the payment determined in this Section; and

2) any applicable adjustments to payment specified in Section 148.290.~~The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:~~

~~1) Hospitals located outside of Illinois.~~

~~2) Hospitals located inside HSA 6.~~

~~3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).~~

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

~~5) A children's hospital, as described in 89 Ill. Adm. Code 149.50(c)(3).~~

c) Rehabilitation Hospital. Payment for inpatient rehabilitation services provided by a rehabilitation hospital, as defined in Section 148.25(d)(2):~~Psychiatric Adjustment Payment Rates~~

1) For which the Department had no inpatient base period claims data, shall be the product of the following:

A) 80 percent of weighted average rehabilitation hospital rate; and

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).~~For a hospital qualifying under subsection (a)(1) of this Section, the rate is $63.00.~~

2) For which the Department had inpatient base period claims data, shall be the product of the following: ~~For a hospital qualifying under subsection (a)(2) of this Section that:~~

A) The greater of:~~Has less than 10,000 total days, the rate is $78.00.~~

i) the hospital's rehabilitation rate, as determined in subsection (e); and

ii) 80 percent of the weighted average rehabilitation hospital rate.

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i)~~Has equal to or greater than 10,000 total days, the rate is $125.00~~.

~~3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is $21.00.~~

~~4) For a hospital qualifying under subsection (a)(4) of this Section, the rate is $38.00.~~

~~5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is $140.00~~

d) Distinct Part Rehabilitation Unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Section 148.25(c)(2): ~~Payment to a Qualifying Hospital~~

1) For which the Department had no inpatient base period paid claims data, shall be the product of the following: ~~The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (c) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.~~

A) The arithmetic mean rate for rehabilitation distinct part units.

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

2) For which the Department had inpatient base period paid claims data, shall be the product of the following:~~The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on at least a quarterly basis.~~

A) The lesser of:

i) The greater of:

- The distinct part rehabilitation unit rate, as determined in subsection (e); and
- The arithmetic mean rate for rehabilitation distinct part units.

ii) The arithmetic mean rehabilitation rate for rehabilitation distinct part units plus the value of one standard deviation of the rehabilitation rate for rehabilitation distinct part units.

e) The rehabilitation rate is calculated as the sum of:

1) The rehabilitation rate in effect on July 1, 2011.

2) The quotient, rounded to the nearest hundredth, of the rehabilitation provider's allocated static payments divided by the rehabilitation provider's inpatient covered days in the inpatient base period paid claims data.

f)~~e)~~ Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to Psychiatric Adjustment Payments, Rural Adjustment Payments, Outpatient Assistance Adjustment Payments, Safety Net Adjustment Payments, Critical Hospital Adjustment Payments (CHAP), Tertiary Care Adjustment Payments and Pediatric Inpatient Adjustment Payments during State fiscal year

(SFY) 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department, allocated to rehabilitation services based on the ratio of rehabilitation claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for rehabilitation payment for services provided in SFY 2015 and 2016.

"Weighted average rehabilitation hospital rate" means the sum of rehabilitation hospital inpatient base period paid claims data total reported payments, excluding Disproportionate Share Hospitals (DSH) and Medicaid Percentage Adjustment/Medicaid High Volume Adjustment (MPA/MHVA), plus rehabilitation hospital total allocated supplemental payments, divided by rehabilitation hospital inpatient base period paid claims data total covered days.

~~1) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.~~

~~2) "Total licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".~~

~~3) "Licensed psychiatric beds" means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".~~

~~4) "Psychiatric occupancy rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".~~

~~5) "MIUR" for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, the MIUR~~

~~determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment Payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.~~

~~6)~~ ~~"Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000 and ending on June 30, 2001.~~

~~7)~~ ~~"Psychiatric Adjustment Payment period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

~~8)~~ ~~"Total psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.~~

~~9)~~ ~~"Total days" means, for a given hospital, the sum of days of inpatient hospital services provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.~~

~~10)~~ ~~"Psychiatric care average length of stay" means the quotient of the fraction, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which is the number of admissions in the Psychiatric Adjustment Payment base year.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 148.110 Reimbursement Methodologies for Inpatient Psychiatric Services~~Base Rate Adjustment Payments~~

Effective for dates of service on or after July 1, 2014:

a) Inpatient psychiatric services not excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed through the DRG PPS.~~Qualifying Criteria~~

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

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

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

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

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

b) Inpatient psychiatric services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsection (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:

1) the payment determined in this Section; and

2) any applicable adjustments to the payment specified in Section 148.290.~~Psychiatric Base Rate Adjustment Payments~~

~~1) For a hospital qualifying under subsection (a)(1) of this Section, the Department shall pay an amount equal to $400.00 less the hospital's per diem rate for Medicaid inpatient psychiatric services in effect on October~~

~~1, 2003, multiplied by the number of Medicaid inpatient psychiatric days provided in the psychiatric base rate period. In no event, however, shall that amount be less than zero.~~

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

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

c) Psychiatric Hospital. Payment for inpatient psychiatric services provided by a psychiatric hospital, as defined in Section 148.25(d)(1):~~Payment to a Qualifying Hospital~~

1) For which the Department had no inpatient base period paid claims data, shall be the product of: ~~For the psychiatric base rate adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (b) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.~~

A) The lowest hospital psychiatric rate determined pursuant to subsection (e); and

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

2) For which the Department had inpatient base period paid claims data, shall be the product of the following:

A) The hospital's psychiatric rate, as determined in subsection (e).

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

~~For the psychiatric base rate adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (b) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions described in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~

~~3) If a hospital closes during the fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

d) Distinct Part Psychiatric Unit. Payment for psychiatric services provided by a distinct part psychiatric unit, as defined in Section 148.25(c)(1): ~~Limitations: Hospitals that qualify for Psychiatric Base Rate Adjustment Payments shall not be eligible for the total Psychiatric Base Rate Adjustment Payment if, during the psychiatric base rate adjustment period, the hospital no longer operates the psychiatric distinct part unit.~~

1) For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A) 80 percent of the arithmetic mean transition rate for psychiatric distinct part units; and

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

2) For which the Department had inpatient base period paid claims data, shall be the product of the following:

A) The lesser of:

i) The greater of:

- The distinct part psychiatric unit rate, as determined in subsection (e); and

- 80 percent of the arithmetic mean psychiatric rate for psychiatric distinct part units.

ii) The arithmetic mean rate for psychiatric distinct part units plus the value of two standard deviations of the psychiatric rate for psychiatric distinct part units.

e) The psychiatric rate is calculated as the sum of:

1) The per diem rate for psychiatric services in effect on July 1, 2011.

2) The quotient, rounded to the nearest hundredth, of the psychiatric provider's allocated static payments divided by the psychiatric provider's inpatient covered days in the inpatient base period paid claims data.

f)~~e)~~ Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.117, 148.126, 148.295, 148.296 and 148.298 during the SFY 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in: http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department, allocated to psychiatric services based on the ratio of psychiatric claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for psychiatric payment for services provided in SFY 2015 and 2016.

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

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

~~3) "Medicaid inpatient psychiatric days" means, for a given hospital, the sum of days of inpatient psychiatric hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act,~~

~~excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the psychiatric base period that were adjudicated by the Department through June 30, 2002.~~

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

~~5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.112 Medicaid High Volume Adjustment Payments

Effective for dates of service on or after July 1, 2014:

a) The Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that are eligible to receive the adjustment payments described in Section 148.122. ~~Qualifying criteria. High Volume Adjustment Payments shall be made~~

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

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

1) A children's hospital, as defined in Section 148.25(d)(3), shall receive an MHVA payment adjustment of $120.~~County-owned hospitals as described in Section 148.25(b)(1)(A).~~

2) Any hospital other than a children's hospital meeting the criteria specified in subsection (a) shall receive an MHVA payment adjustment of $60. ~~Hospitals organized under the University of Illinois Hospital Act [110 ILCS 330], as described in Section 148.25(b)(1)(B).~~

3) The amount calculated pursuant to subsections (b)(1) and (b)(2) shall be adjusted as authorized in Section 5-5.02 of the Illinois Public Aid Code. ~~A hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~

c) Payment~~High Volume Adjustment Payments1)~~The adjustments calculated under this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided so long as the hospital meets the criteria specified in subsection (a) on the covered day. ~~For a hospital qualifying under subsection (a) of this Section, the Department shall pay the product of $190.00 multiplied by the qualifying hospital's Medicaid inpatient days.~~

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

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

~~d) Payment to a Qualifying Hospital~~

~~1) For the high volume adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c) of this Section multiplied by the proration factor and shall be paid to the hospital within 75 days after the conditions described in subsection (f) of this Section have been met.~~

~~2) For the high volume adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection (c) of this Section and shall be paid to the hospital in four equal installments on or before July 15, 2004, October 15, 2004, January 14, 2005 and April 15, 2005. The sum of the amounts, required prior to the conditions in subsection (f) being met, shall be paid within 75 days after the conditions in subsection (f) have been met.~~

~~3) If a hospital closes during fiscal year, payments will be prorated based on the number of days the hospital was open during the fiscal year.~~

~~e) Definitions~~

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

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

~~3) "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's~~

~~paid claims data for admissions occurring in the high volume base period that were adjudicated by the Department through June 30, 2002.~~

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

~~5) "Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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

~~1) the methodologies described in this Section receive federal approval from the Centers for Medicare and Medicaid Services in an appropriate State Plan Amendment;~~

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.115 Reimbursement Methodologies for Long Term Acute Care Services~~Rural Adjustment Payments~~

Effective for dates of service on or after July 1, 2014:

a) Inpatient long term acute care psychiatric services excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b) shall be reimbursed under the inpatient psychiatric services methodologies specified in Section 148.110.~~Qualifying Criteria~~

~~Rural Adjustment Payments shall be made to all qualifying general acute care hospitals that are designated as a Critical Access Hospital or a Necessary Provider, as designated by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F (2001), as of the first day of July in the Rural Adjustment Payment rate period.~~

b) Inpatient long term acute care services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to this Section. The total payment for an inpatient stay will equal the sum of:

1) the payment determined in this Section; and

2) any applicable adjustments to payment specified in Section 148.290.~~Rural Adjustment Rates~~

~~1) Inpatient Component~~
~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows:~~

~~A) Total inpatient payments, as described in subsection (d)(2) of this Section, shall be divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient payment per day.~~

~~B) Total inpatient charges, associated with inpatient days as described in subsection (d)(4) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total inpatient cost.~~

~~C) Total inpatient costs, as defined in subsection (b)(1)(B) of this Section, are divided by the total inpatient days, as described in subsection (d)(4) of this Section, to derive an inpatient cost per day.~~

~~D) Inpatient payment per day, as defined in subsection (b)(1)(A) of this Section, shall be subtracted from the inpatient cost per day, as described in subsection (b)(1)(C) of this Section, to derive an~~

~~inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.~~

~~E)~~ ~~Inpatient cost coverage deficit per day, as described in subsection (b)(1)(D) of this Section, shall be multiplied by the total inpatient days, as described in subsection (d)(4) of this Section, to derive a total hospital specific inpatient cost coverage deficit.~~

~~F)~~ ~~The inpatient cost deficits, as described in subsection (b)(1)(E) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.~~

~~2)~~ ~~Outpatient Component~~
~~For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows:~~

~~A)~~ ~~Total outpatient payments, as defined in subsection (d)(3) of this Section, shall be divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient payment per service unit.~~

~~B)~~ ~~Total outpatient charges, associated with outpatient services, as defined in subsection (d)(5) of this Section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(1) of this Section, to derive total outpatient cost.~~

~~C)~~ ~~Total outpatient costs, as defined in subsection (b)(2)(B) of this Section, are divided by the total outpatient services, as described in subsection (d)(5) of this Section, to derive an outpatient cost per service unit.~~

~~D)~~ ~~Outpatient payment per service unit, as defined in subsection (b)(2)(A) of this Section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(2)(C) of this Section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.~~

~~E) Outpatient cost coverage deficit per service unit, as described in subsection (b)(2)(D) of this Section, shall be multiplied by the total outpatient services, as described in subsection (d)(5) of this Section, to derive a total hospital specific outpatient cost coverage deficit.~~

~~F) The outpatient cost coverage deficits, as described in subsection (b)(2)(e) of this Section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.~~

~~3) Payment Methodology~~
~~A $7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:~~

~~A) The total inpatient cost coverage deficit, as described in subsection (b)(1)(F) of this Section, is added to the total outpatient cost coverage deficit, as described in subsection (b)(2)(F) of this Section, to derive a total Rural Adjustment Payment base year deficit.~~

~~B) The inpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total inpatient cost deficit, as described in subsection (b)(1)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~

~~C) The outpatient pool allocation percentage shall be the quotient of the fraction, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(2)(F) of this Section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in subsection (b)(3)(A) of this Section.~~

~~D) An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (b)(3)(B) of this Section, multiplied by the $7 million pool, as described in subsection (b)(3) of this Section.~~

~~E) The outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(3)(C) of this Section, multiplied by the $7 million pool, as described in subsection (b)(3) of this Section.~~

~~F) An inpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the inpatient pool allocation, as described in subsection (b)(3)(D) of this Section, the denominator of which shall be the total inpatient cost deficit as described in subsection (b)(1)(F) of this Section.~~

~~G) An outpatient residual cost coverage factor shall be the quotient of the fraction, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(3)(E) of this Section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(2)(F) of this Section.~~

~~H) The hospital specific inpatient cost coverage adjustment amount shall be the product of the inpatient residual cost coverage factor, as described in subsection (b)(3)(F) of this Section, multiplied by the hospital specific inpatient cost coverage deficit, as described in subsection (b)(1)(E) of this Section.~~

~~I) The hospital specific outpatient cost coverage adjustment amount shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(3)(G) of this Section, multiplied by the hospital specific outpatient cost coverage deficit, as described in subsection (b)(2)(E) of this Section.~~

c) Payment for long term acute care services provided by a long term acute care hospital, as defined in Section 148.25(d)(4): ~~Payment to a Qualifying Hospital~~

1) For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A) $604.00; and

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

~~The total annual adjustment amount to a qualified hospital shall be the sum of the hospital specific inpatient cost coverage adjustment amount, as described in subsection (b)(3)(H) of this Section, plus the hospital specific outpatient cost coverage adjustment amount, as described in subsection (b)(3)(I) of this Section.~~

2) For which the Department had inpatient base period paid claims data, shall be the product of the following: ~~The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(7) of this Section, on at least a quarterly basis.~~

A) The hospital-specific rate, as determined in subsection (d).

B) The length of stay, as defined in 89 Ill. Adm. Code 149.100(i).

d) The hospital-specific rate is calculated as the sum of:

1) The per diem rate for long term acute care services in effect on July 1, 2011.

2) The quotient, rounded to the nearest hundredth, of the hospital's allocated static payments divided by the hospital's covered days in the inpatient base period paid claims data.

e)~~d)~~ Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to Sections 148.105, 148.115, 148.117, 148.126, 148.295 and 148.298 during SFY 2011 pursuant to the methodologies outlined in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department, allocated to long-term acute care services based on the ratio of long-term acute care claim charges, excluding psychiatric claim charges, to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means SFY 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims.

f) Long Term Acute Care Supplemental Per Diem Rates.

1) The long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], shall be the amount in effect as of October 1, 2010.

2) No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.

~~1) "Hospital cost to charge ratio" means the quotient of the fraction, the numerator of which is the cost as reported on Form CMS 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form CMS 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, and, for SFY 2004, the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.~~

~~2) "Inpatient payments" shall mean all payments associated with total days provided, as described in subsection (d)(4) of this Section, and all quarterly adjustment payments paid, as described throughout Part 148, excluding the Rural Adjustment Payments described in this Section.~~

~~3) "Outpatient payments" shall mean all payments associated with total outpatient services provided, as described in subsection (d)(5) of this Section, and all quarterly adjustment payments paid, as described in this Part, excluding the Rural Adjustment Payments described in this Section.~~

~~4) "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~

~~5) "Total outpatient services" means the number of outpatient services provided during the Rural Adjustment Payment base year to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~

~~6) "Rural Adjustment Payment base year" means, for the Rural Adjustment Payment rate period beginning October 1, 2002, SFY 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, SFY 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.~~

~~7) "Rural Adjustment Payment rate period" means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of that year and ending June 30 of the following year.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.116 Reimbursement Methodologies for Children's Specialty Hospitals

Effective for dates of service on or after July 1, 2014:

a) Inpatient general acute care services provided by a Children's Specialty Hospital, as defined in Section 148.25(i) and excluded from the DRG PPS pursuant to 89 Ill. Adm. Code 149.50(b), shall, per day of covered inpatient care, be reimbursed as follows:

1) For a hospital that would not have met the definition of a children's specialty hospital as of July 1, 2013, $1,400.00 per day.

2) For a hospital that would have met the definition of a children's specialty hospital as of July 1, 2013, a rate equal to the per diem base rate in place on July 1, 2013, multiplied by a factor of 1.37.

3) The total payment for inpatient stay will equal the sum of:

A) The payment determined in this Section; and

B) Any applicable adjustments to payment specified in Section 148.290.

b) Hospital outpatient and clinic services shall be reimbursed in accordance with Section 148.140.

c) Access to Outpatient Care

1) To ensure access to outpatient care and maintain stability for children's specialty hospitals, the Department shall make annual outpatient transitional payments equal to the difference of:

A) The amount of static payments made to the hospital in SFY 2011 in accordance with the Safety Net Adjustment Payments, Critical Hospital Adjustment Payments (CHAP), Tertiary Care Adjustment Payments, Pediatric Outpatient Adjustment Payments and Pediatric Inpatient Adjustment Payments pursuant to the methodologies outlined in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx; and

B) .8695.

2) The annual amount determined in this Section shall be paid in monthly installments equal to 1/12 of the annual amount.

d) The reimbursement methodologies in this Section shall be re-determined prior to July 1, 2016 if implementation of reform to hospital non-institutional service reimbursement occurs. In the absence of reform to hospital non-institutional service reimbursement, the reimbursement methodologies in this Section shall be re-determined to be effective on or after July 1, 2016.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.117 Outpatient Assistance Adjustment Payments

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Effective for dates of service on or after July 1, 2014, except when specifically designated otherwise in this Section:

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

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

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

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

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

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

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

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

6)~~8)~~ A general acute care hospital, not located in Cook County, that is a Level I trauma center recognized by DPH as of July 1, 2006, has an emergency care percentage greater than 50%, and provided more than 16,000 Medicaid outpatient ambulatory procedure listing services, including more than 1,000 non-emergency screening outpatient ambulatory procedure listing services, in the outpatient assistance base year.

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

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

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

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

surgical group outpatient ambulatory procedure listing services, in the outpatient assistance base year.

~~13) A general acute care hospital located outside of Illinois that provided more than 300 high tech diagnostic Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~

~~14) A general acute care hospital is recognized as a Level I trauma center by DPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~

b) Outpatient Assistance Adjustment Payments

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

1)~~2)~~ For hospitals qualifying under subsection (a)(1~~2~~), the rate is $850.00 for dates of service through February 28, 2014. For dates of service on March 1, 2014 through June 30, 2014, the rate is $1,523.00. For dates of service on or after July 1, 2014, the rate is $0.00.

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

2)~~4)~~ For hospitals qualifying under subsection (a)(2~~4~~), the rate is $290.00 for dates of service on July 1, 2014 ~~$665.00~~ through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00~~$375.00~~.

3)~~5)~~ For hospitals qualifying under subsection (a)(3~~5~~), the rate is $250.00 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

4)~~6)~~ For hospitals qualifying under subsection (a)(4~~6~~), the rate is $336.25 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

5)~~7)~~ For hospitals qualifying under subsection (a)(5~~7~~), the rate is $110.00 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

6)~~8)~~ For hospitals qualifying under subsection (a)(6~~8~~), the rate is $200.00 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

7)~~9)~~ For hospitals qualifying under subsection (a)(7~~9~~), the rate is $173.50 for dates of service on July 1, 2014 through December 31, 2014.~~$128.50 through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $74.00, to $202.50. For dates of service on or after July 1, 2012 through December 31, 2014, the rate is $247.50.~~ For dates of service on or after January 1, 2015, the rate is $0.00~~$48.50~~.

8)~~10)~~ For hospitals qualifying under subsection (a)(8~~10~~), the rate is $135.00 for dates of service on July 1, 2014 through December 31, 2014.~~ For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by $70.00, to $205.00.~~ For dates of service on or after January 1, 2015, the rate is $0.00~~$135.00~~.

9)~~11)~~ For hospitals qualifying under subsection (a)(9~~11~~), the rate is $65.00 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

10)~~12)~~ For hospitals qualifying under subsection (a)(10~~12~~), the rate is $90.00 for dates of service on July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

~~13) For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 19% but less than 25%, the rate is $141.00. For hospitals qualifying under subsection (a)(13) that have an emergency care percentage greater than 25%, the rate is $494.00.~~

~~14) For hospitals qualifying under subsection (a)(14), the rate is $47.00 for dates of service on or after July 1, 2010 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

c) Payment to a Qualifying Hospital

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

2) For the outpatient assistance adjustment period for fiscal year 2010 and after, total payments will equal the amount determined using the methodologies described in subsection (c)(1) ~~of this Section~~ and shall be paid to the hospital, at least, on a quarterly basis.

3) Payments described in this Section are subject to federal approval.

d) Definitions

1) "Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services as described in Section 148.140(b)(1)(C), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006, and the denominator of which is the total ambulatory procedure listing services as described in Section 148.140(b)(1), excluding services for individuals eligible for Medicare, provided by the hospital in State fiscal year 2005 contained in the Department's data base adjudicated through June 30, 2006.

2) "General acute care hospital" is a hospital that does not meet the definition of a hospital contained in Section 148.25(a) and (d)~~89 Ill. Adm. Code 149.50(c)~~.

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

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

beginning July 1, 2007, the 12-month period beginning July 1 of the year and ending June 30 of the following year.

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

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

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

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

e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.

f) No payments shall be made pursuant to this Section for dates of service after December 31, 2014.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Effective for dates of service on or after July 1, 2014:
~~Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter unless otherwise noted.~~

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

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

2) The hospital's low income utilization rate, as defined in subsection (i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.~~

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

hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform nonemergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in Section 148.25(d),~~89 Ill. Adm. Code 149.50(c)(1) through (c)(4),~~ must submit a statement to that effect.

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

1) Hospital Cost Reports

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

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

C) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4), that have been derived from unaudited cost

reports are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(1)(B), hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination. ~~In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or unaudited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.~~

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

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

~~D) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (i)(4) of this Section, which have been derived from unaudited cost reports or the HDSC form, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsections~~

~~(c)(1)(B) and (c)(1)(C)(ii) of this Section, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.~~

D)~~E)~~ In the event a subsequent final audited cost report reflects an MIUR, as described in subsection (i)(4)~~ of this Section~~, that~~which~~ is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made if the percentage change in the DSH payment rate is greater than five percent.

2) Days Not Available from Cost Report
Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid managed care entity (MCE)~~Health Maintenance Organization (HMO)~~ days, hospital residing long term care days, and Medicaid days for alcohol and substance abuse sub-acute~~rehabilitative~~ care under category of service 035. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year.

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

~~ii) For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to~~

~~the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.~~

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

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

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

E) Alcohol and Substance Abuse Days. The Department will utilize

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

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

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

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

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

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

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the federal~~Federal~~ definition of a DSH hospital (42 USC 1396-4(b)(1))~~, as defined in section 1923(b)(1) of the Social Security Act,~~ may qualify for DSH hospital adjustments under this Section. For purposes of determining the MIUR, as described in subsection (i)(4) ~~of this Section~~ and as required in the federal definition (42 USC 1396r-4(b)(1)),~~section 1923(b)(1) of the Social Security Act,~~ out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the MIUR from their state may submit an audited certified financial

statement as described in subsection (d)~~ of this Section~~. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g) ~~of this Section~~.

f) Time Limitation Requirements for Additional Information.

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

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

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

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

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

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

utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) ~~of this Section~~ in proportion to the percentage by which the hospital's MIUR exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (i)(3) ~~of this Section~~. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

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

2) Department of Human Services (DHS) State-Operated Facility Adjustment for Hospitals Defined in Section 148.25(a)(3)~~148.25(b)(6)~~. DHS~~Department of Human Services~~ State-operated facilities qualifying

under subsection (a)(2) ~~of this Section~~ shall receive an adjustment ~~for inpatient services provided on or after March 1, 1995. Effective October 1, 2000, the adjustment payment shall be~~ calculated as follows:

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

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(a)(3)~~148.25(b)(6)~~ that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uncompensated care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uncompensated care costs.

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

D) The adjustment calculated pursuant to subsection (g)(2)(B) ~~of this Section~~, for each hospital defined in Section 148.25(a)(3)~~148.25(b)(6)~~ that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in subsection (h) ~~of this Section~~. The adjustment described in this subsection (g)(2)(D) shall be paid on a quarterly basis.

3) Assistance for Certain Public Hospitals

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

Protection Act of 2000 (Public Law 106-554).

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

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

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

iii) Divided secondly by the sum of the qualified hospitals' total Medicaid inpatient days, as defined in subsection (i)(4)~~ of this Section~~; and

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

C) The annual payment adjustment calculated under this subsection (g)(3), for each qualified hospital, will be divided by four and paid on a quarterly basis.

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

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

4) Disproportionate Share Payments for Certain Government-Owned or -Operated Hospitals

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

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

ii) Hospitals owned or operated by a unit of local government that is located within Illinois and is not a hospital defined in subsection (i)~~(g)(4)(A)(i) of this Section~~.

~~iii) Hospital defined in Section 148.25(b)(1)(B).~~

B) The annual amount of the payment shall be the amount computed for the hospital pursuant to federal limitations.

C) The annual amount shall be paid to the hospital in monthly installments. ~~The portion of the annual amount not paid pending federal approval of payments shall, upon that approval, be paid in a single lump sum payment. Except as indicated in this subsection (g)(4)(C), the annual amount shall be paid to the hospital in 12 equal installments and paid monthly.~~

h) DSH Adjustment Limitations~~.~~

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues provision of nonemergency obstetrical care. The provisions of this subsection (h)(1) shall not apply to those hospitals described in Section 148.25(d)~~89 Ill. Adm. Code 149.50(c)(1) through (c)(4)~~ or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987. In this instance, the adjustments calculated under subsection (g)(1) shall cease to be effective on the date that the hospital discontinued the provision of such nonemergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment

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

3) DSH Payment Adjustment. If~~In accordance with Public Law 102-234, if~~ the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the federal Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. Subject to any limitation, disproportionate share payments will be made to qualifying hospitals in the following order:

A) Hospitals defined in Section 148.25(a)(3)~~Psychiatric hospitals operated by the Illinois Department of Human Services~~ – the annual amount shall be credited quarterly via certification of public expenditure.

B) Hospitals defined in Section 148.25(a)(2)~~148.25(b)(1)(B)~~.

C) Hospitals defined in subsection (g)(4)(A)(ii) of this Section.~~owned and operated by a unit of local government that is not a hospital defined in Section 148.25(b)(1)(A).~~

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

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

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of estimated Medicaid payments (inpatient, outpatient, and disproportionate share) to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. Federal upper payment limit requirements (42 CFR 447.272) shall be considered when calculating the OBRA'93

adjustments. The adjustments shall reduce disproportionate share spending until the costs and spending (described in this subsection (h)(4)) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.

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

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

1) "Base fiscal year" means ~~, for example,~~ the hospital's fiscal year ending in the calendar year 22 months before the beginning of the~~2001 for the October 1, 2003 DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004~~ DSH determination year~~, etc~~.

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

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the federal~~Federal~~ Social Security Act (42 USC 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals.~~ Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) but does include the types of days described in subsections (c)(1) and (c)(2) of this Section.~~ In this subsection (i)(3), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Medicaid inpatient utilization rate" means a fraction, the numerator of

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

5) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

6) "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of the amount resulting from the calculations in subsection (i)(6)(A) plus (i)(6)(B):

A) The quotient resulting from dividing:

i) the sum of the total Medicaid revenues paid the hospital under this Section for patient services and cash subsidies for patient services received directly from State and local governments, by

ii) the total revenues (including the amount of the cash subsidies) of the hospital for patient services.

B) The quotient resulting from dividing:

i) the hospital's charges for inpatient hospital services that are attributable to charity care in a period (not including contractual allowances and discounts, other than for indigent patients not eligible for Medicaid under an approved State plan) less the portion of any cash subsidies described in subsection (i)(6)(A)(i) reasonably attributable to inpatient hospital services, by

ii) total inpatient charges attributable to charity care.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.122 Medicaid Percentage Adjustments

Effective for dates of service on or after July 1, 2014, the~~The~~ Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1 of each year~~October 1, 2003, and each October 1 thereafter~~ unless otherwise noted.

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

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

2) The hospital's low income utilization rate, as defined in Section 148.120(i)(6), exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.~~

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

4) Illinois hospitals that meet the following criteria:

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

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

5) Any children's hospital, as defined in Section 148.25(d)(3)~~89 Ill. Adm. Code 149.50(c)(3)~~.

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

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

c) Hospitals that~~may apply to become a~~ qualified as a Medicaid Percentage Adjustment hospital under subsection (a)(2) for the Medicaid percentage determination year beginning October 1, 2013 may apply annually to become qualified under subsection (a)(2)~~ of this Section~~ by submitting audited certified financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

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

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

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

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

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

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

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

3) The amount calculated pursuant to subsections (d)(1) through (d)(2) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(i)(2), through DSH determination year 2014~~2003~~, ~~and annually thereafter,~~ by a percentage equal to the lesser of:

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

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

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

e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section 148.25(d)(3)~~89 Ill. Adm. Code 149.50(c)(3)~~, the payment adjustment calculated under subsection (d)(1) ~~of this Section~~ shall be multiplied by 2.0.

f) Medicaid Percentage Adjustment Limitations.

1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in Section 148.25(d)~~89 Ill. Adm. Code 149.50(c)(1) through (c)(4)~~, must submit a statement to that effect.

2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of non-emergency obstetrical care. The provisions of this subsection (f)(2) shall not apply to those hospitals described in Section 148.25(d)~~89 Ill. Adm. Code 149.50(c)(1) through~~

~~(c)(4)~~ or those hospitals that have not offered non-emergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of ~~such~~ non-emergency obstetrical care.

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

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

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

1) "Medicaid Percentage determination year" has the same meaning as the DSH determination year defined in Section 148.120(i)(2)~~means the 12 month period beginning on October 1 of the year and ending September 30 of the following year~~.

2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4)~~ of this Section~~, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal~~Federal~~ Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (g)(6)~~ of this Section~~, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were

subsequently adjudicated by the Department through the last day of June preceding the Medicaid percentage~~DSH~~ determination year and contained within the Department's paid claims data base.

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

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

A) 370 through 375 for claims adjudicated before July 1, 2014; or

B) 540, 541, 542 or 560 for claims adjudicated on or after July 1, 2014.

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

5)~~6)~~ "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3)~~ of this Section~~, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid

Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

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

8) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.126 Safety Net Adjustment Payments

Effective for dates of service on or after July 1, 2014, except when specifically designated otherwise in this Section:

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

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

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

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

2~~4~~) The hospital is, as of October 1, 2001, a rural hospital, as described in

Section 148.446(a)(1)~~148.25(g)(3)~~, that meets all of the following criteria:

A) Has an MIUR greater than 33 percent.

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

C) Has fewer than 125 licensed beds.

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

3~~6~~) The hospital meets all of the following criteria:

A) Has an MIUR greater than 30 percent.

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

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

4~~7~~) The hospital meets all of the following criteria:

A) Does not already qualify under subsections (a)(1) through (a)(3)~~(6) of this Section~~.

B) Has an MIUR greater than 25 percent.

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

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

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

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

~~B)~~ ~~Has an MIUR greater than 18 percent.~~

~~C) Has a combined MIUR greater than 45 percent.~~

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

~~E) Provided greater than 400 total days.~~

~~F) Provided fewer than 125 obstetrical care days.~~

5~~9~~) The hospital meets all of the following criteria in the safety net base year:

A) Is a psychiatric hospital, as described in Section 148.25(d)(1)~~89 Ill. Adm. Code 149.50(c)(1)~~.

B) Has licensed beds greater than 120.

C) Has an average length of stay less than 10~~ten~~ days.

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

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

~~B) Has an MIUR greater than 17 percent.~~

~~C) Has licensed beds greater than 450.~~

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

6~~11~~) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(5)~~(10) of this Section~~.

B) Has an MIUR greater than 21 percent.

C) Has licensed beds greater than 350.

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

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

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

~~B) Has an MIUR greater than 34 percent.~~

~~C) Has licensed beds greater than 350.~~

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

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

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

~~B) Has an MIUR greater than 35 percent.~~

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

7~~14~~) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(6)~~(13) of this Section~~.

B) Has a Combined MIUR greater than 25 percent.

C) Has an MIUR greater than 12 percent.

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

E) Has licensed beds greater than 400.

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

~~15) A hospital provider that would otherwise be excluded from payment by~~

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

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

8~~17~~) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(7)~~(16) of this Section~~.

B) Is located outside Health Service Area (HSA) 6.

C) Has an MIUR greater than 16%.

D) Has licensed beds greater than 475.

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

9~~18~~) The hospital meets all of the following criteria in the safety net base year:

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

B) Has a combined MIUR greater than 80%.

10~~19~~) The hospital meets all of the following criteria in the safety net base year:

A) Does not already qualify under subsections (a)(1) through (a)(9)~~(18) of this Section~~.

B) Has a CMIUR greater than 28 percent.

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

D) Has licensed beds greater than 320.

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

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

~~20) The hospital meets all of the following criteria in the safety net base year:~~

~~A) Does not already qualify under subsections (a)(1) through (a)(19) of this Section.~~

~~B) Is a general acute care hospital.~~

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

~~D) Provided greater than 1,000 rehabilitation days in the safety net hospital base year.~~

~~21) The hospital meets all of the following criteria in the safety net base year:~~

~~A) Qualifies as a children's hospital under subsection (c)(1) of this Section.~~

~~B) Has an average length of stay less than 3.25 days.~~

~~C) Provided greater than 1,000 total days in the safety net hospital base year.~~

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

~~1) Hospitals located outside of Illinois.~~

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

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

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

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

~~e) Safety Net Adjustment Rates~~

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

~~A) A qualifying hospital – $15.00.~~

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

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

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

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

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

~~E) A children's hospital that has an MIUR less than 80 per centum, but greater than or equal to 60 per centum, that is:~~

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

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

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

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

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

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

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

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

~~i) Provides obstetrical care – $10.00.~~

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

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

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

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

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

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

b~~J~~) For a hospital qualifying under subsection (a)(1) that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centrum, and that:

1) Provides obstetrical care – $210.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

2) Does not provide obstetrical care – $90.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

c) For a hospital qualifying under subsection (a)(2), the rate shall be $55.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

d) For a hospital qualifying under subsection (a)(3), the rate is $3.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

e) For a hospital qualifying under subsection (a)(4), the rate is $140.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

f) For a hospital qualifying under subsection (a)(5), the rate is $47.50 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

g) For a hospital qualifying under subsection (a)(6), the rate is $221.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

h) For a hospital qualifying under (a)(7), the rate is $100.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

i) For a hospital qualifying under subsection (a)(8), the rate is $69.00. The reimbursement rate is contingent on federal approval through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.

j) For a hospital qualifying under subsection (a)(9), the rate is $56.00 for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is $136.00. For dates of service on or after July 1, 2014 through December 31, 2014, the rate is $56.00. For dates of service on or after January 1, 2015, the rate is $0.00.

k) For a hospital qualifying under subsection (a)(10), the rate is $84.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00. ~~A qualifying hospital that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centum, and that:~~

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

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

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

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

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

~~2) For a hospital qualifying under subsection (a)(2) of this Section, the rate shall be $123.00 for dates of service through March 2, 2013. The rate shall be increased by $121.00, to $244.00, for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate shall be $123.00.~~

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

~~A) A qualifying hospital – $40.00.~~

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

~~days, and:~~

~~i) More than 150 licensed beds – $20.00.~~

~~ii) Fewer than 150 licensed beds – $40.00.~~

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

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

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

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

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

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

~~B) The greater of:~~

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

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

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

~~7) For a hospital qualifying under subsection (a)(7) of this Section, the rate is $315.50 through December 31, 2014 if federal approval is received by the~~

~~Department for that rate; otherwise, the rate shall be $210.50. For dates of service on or after January 1, 2015, the rate is $210.50.~~

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

~~9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is $133.00. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by $72.00, to $205.00. For dates of service on or after January 1, 2015, the rate is $85.50.~~

~~10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is $13.75. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by $25.00, to $38.75. For dates of service on or after January 1, 2015, the rate is $13.75.~~

~~11) For a hospital qualifying under subsection (a)(11) of this Section, the rate is $421.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $39.50.~~

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

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

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

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

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

~~17) For a hospital qualifying under subsection (a)(18) of this Section, the rate is $56.00 through December 31, 2014. For dates of service on or after~~

~~January 1, 2015, the rate is $16.00. This reimbursement rate is contingent on federal approval.~~

~~18)~~ ~~For a hospital qualifying under subsection (a)(19) of this Section, the rate is $229.00. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by $113.00, to $342.00. For dates of service on or after January 1, 2015, the rate is $145.00.~~

~~19)~~ ~~For a hospital qualifying under subsection (a)(20) of this Section, the rate is $71.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

~~20)~~ ~~For a hospital qualifying under subsection (a)(21) of this Section, the rate is $1986.00 for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate is $0.00.~~

l~~d~~) Payment to a Qualifying Hospital

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

2) For the safety net adjustment period occurring in State fiscal year 2011, total payments will be determined through application of the methodologies described in subsection (c)~~ of this Section~~.

3) For safety net adjustment periods occurring after State fiscal year 2010, total payments made under this Section shall be paid in installments on, at least, a quarterly basis.

m~~e~~) Definitions

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

2) "CMIUR" means, for a given hospital, the sum of the MIUR plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, as defined in Section 148.122(g)(3)~~148.120(i)(6)~~.

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

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

5) "Licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, DPH~~Illinois Department of Public Health~~ report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

6) "MIUR", for a given hospital, has the meaning as defined in Section 148.120(i)(4)~~(5)~~ and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for safety net adjustment payments in the Safety Net Adjustment Period.

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

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

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

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

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

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

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

n~~f~~) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 must be a Coordinated Care Participating Hospital as defined in Section 148.295(g)(5). The payment limitation takes effect six months after the

Department begins mandatory enrollment in the geographic area.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.140 Hospital Outpatient and Clinic Services

Effective for dates of service on or after July 1, 2014:

a) Fee-For-Service Reimbursement

1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:

A) Services ~~Those services that meet the definition of the Ambulatory Procedure Listing (APL) as~~ described in subsection (b)(1) ~~of this Section~~.

B) End stage renal disease treatment (ESRDT) services, as described in subsection (c) ~~of this Section~~.

~~C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D).~~

C~~D~~) Those services provided by a Critical Clinic Provider as described in subsection (e) ~~of this Section~~.

2) Except for the services reimbursed ~~procedures~~ under the EAPG PPS, ~~APL groupings~~ described in subsection (b)(1) ~~of this Section~~, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

3) Hospitals are required to bill the Department utilizing specific service codes. All specific client coverage policies (relating to client eligibility

and scope of services available to those clients) that pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee-for-service.~~With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

~~A) The reimbursement rates described in subsection (a)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~

~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

4) Payments under Section 148.140(a)(4) shall cease as of June 30, 2014 for Maternal and Child Health Program Clinics. ~~rates, as described in 89 Ill. Adm. Code 140, Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Maternal and Child Health Program rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Maternal and Child Health Program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).~~

~~5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.~~

~~6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall~~

~~be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~

~~7) With the exception of the retrospective adjustment described in subsection (a)(3) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section.~~

b) EAPG PPS Reimbursement. Reimbursement under EAPG PPS, described in subsection (c), shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in subsection (b)(3), no separate reimbursement will be made for ancillary services or the services of hospital personnel.

1) Outpatient hospital services reimbursed through the EAPG PPS shall include:

A) Surgical services.

B) Diagnostic and therapeutic services.

C) Emergency department services.

D) Observation services.

E) Psychiatric treatment services.

2) Excluded from reimbursement under the EAPG PPS are outpatient hospital services reimbursed pursuant to 59 Ill. Adm. Code 131 and 132, 77 Ill. Adm. Code 2090, and Section 148.330 of this Part.

3) Exceptions to All-inclusive EAPG PPS Rate

A) A hospital may bill separately for:

i) Professional services of a physician who provided direct patient care.

ii) Chemotherapy services provided in conjunction with radiation therapy services.

iii) Physical rehabilitation, occupational or speech therapy services provided in conjunction with an APG PPS reimbursed service.

B) For the purposes of subsection (b)(3)(A), a physician means:

i) A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for those providers.

ii) A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.

iii) A group of physicians with a financial contract to provide emergency department care.

c) EAPG PPS Payment. The reimbursement to hospitals for outpatient services provided on the same day shall be the product, rounded to the nearest hundredth, of the following:

1) The EAPG weighting factor of the EAPG to which the service was assigned by the EAPG grouper.

2) The EAPG conversion factor, based on the sum of:

A) The product, rounded to the nearest hundredth, of:

i) the labor-related share;

ii) the Medicare IPPS wage index; and

iii) the applicable EAPG standardized amount.

B) The product, rounded to the nearest hundredth, of:

i) non-labor share; and

ii) the applicable EAPG standardized amount.

3) The applicable consolidation factor.

4) The applicable packaging factor.

5) The applicable discounting factor.

6) The applicable policy adjustment factors, as defined in subsection (f), for which the service qualifies.

d) EAPG Standardized Amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:

1) County-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(1), the EAPG standardized amount is determined in Section 148.160.

2) University-operated Large Public Hospital EAPG Standardized Amount. For a large public hospital, as defined in Section 148.25(a)(2), the EAPG standardized amount is determined in Section 148.170.

3) Critical Access Hospital EAPG Standardized Amount. For critical access hospitals, as defined in Section 148.25(g), the EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Section 148.456 net of tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

4) Acute EAPG Standardized Amount

A) Qualifying Criteria. General acute hospitals excluding providers in subsections (d)(1) through (d)(3), freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.

B) The acute EAPG standardized amount is based on a single statewide amount determined such that:

i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using general acute hospital outpatient base period paid claims data, result in approximately a $75 million increase compared to the amount derived in subsection (d)(4)(B)(ii).

ii) The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.

5) Psychiatric EAPG Standardized Amount

A) Qualifying Criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.

B) The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:

i) Simulated EAPG payments, without policy adjustments defined in subsection (f), using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments approximately equal to the amount derived in subsection (d)(5)(B)(ii).

ii) The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

6) Rehabilitation EAPG Standardized Amount

A) Qualifying Criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.

B) The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:

i) Simulated EAPG payments, without SMART Act reductions or policy adjustments defined in subsection (f), using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to the annual derived in subsection (d)(6)(B)(ii).

ii) The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

7) Ambulatory Surgical Treatment Center (ASTC) EAPG Standardized Amount. For ASTC's, as defined in 89 Ill. Adm. Code 146.105, the EAPG standardized amount is determined such that simulated EAPG payments using outpatient base period paid claims data are equal to reported payments of outpatient base period paid claims data as contained in the Department's claims data warehouse.

e) Discounting factor. The applicable discounting factor is based on the discounting flags designated by the EAPG grouper under default EAPG settings:

1) The discounting factor will be 1.0000, if the following criteria are met:

A) The service has not been designated with a Bilateral Procedure Discounting flag, Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or

B) The service has not been designated with a Bilateral Procedure Discounting flag and has been designated with a Multiple Procedure Discounting flag by the EAPG grouper under default EAPG settings and the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

2) The discounting factor will be 0.5000 if the following criteria are met:

A) The service has been designated with a Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day; and

B) The service has not been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings.

3) The discounting factor will be 0.7500 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

4) The discounting factor will be 1.5000 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has not been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or if the Multiple Procedure Discounting flag is present, the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

f) Policy Adjustments. Claims for services by providers that meet certain criteria shall qualify for further adjustments to payment. If a claim qualifies for more than one policy adjustment, then the EAPG PPS payment will be multiplied by both factors.

1) Safety Net Hospital Qualifying Criteria

A) The service is described in subsection (b)(1), excluding Medicare crossover claims.

B) The hospital is a Safety Net hospital, as defined in Section 5-5e.1 of the Illinois Public Aid Code that is not:

i) A critical access hospital, as defined in Section 148.25(g).

ii) A large public hospital, as defined in Section 148.25(a).

C) Policy adjustment factor effective SFY 2015 and 2016 is 1.3252.

2) High Outpatient Volume Hospital Qualifying Criteria

A) The service is described in subsection (b)(1), excluding Medicare crossover claims.

B) The hospital is a High Outpatient Volume hospital, as defined in subsection (f)(2)(C) that is not:

i) A critical access hospital, as defined in Section 148.25(g).

ii) A large public hospital, as defined in Section 148.25(a).

iii) A Safety Net hospital, as defined in Section 5-5e.1 of the Illinois Public Aid Code.

C) A High Outpatient Volume hospital for which the high outpatient volume is at least:

i) 1.5 standard deviations above the mean regional high outpatient volume; or

ii) 1.5 standard deviations above the mean statewide high outpatient volume.

D) Policy adjustment factor effective SFY 2015 and 2016 is 1.3252.

3) Crossover Adjustment Factor

A) Acute EAPG standardized amounts, as defined in subsection (f)(2)(C), shall be reduced by a Crossover Adjustment factor such that:

i) The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment Factor to simulated EAPG payments, including Policy Adjustments, using general acute hospital outpatient base period paid claims data, is equal to the amount derived in subsection (f)(3)(A)(ii):

ii) The difference of total simulated EAPG payments using general acute hospital outpatient crossover paid claims data, and general acute hospital outpatient crossover paid claims data total reported Medicaid net liability.

B) Crossover Adjustment Factor effective SFY 2015 and 2016 is 0.98912.

4) If a claim does not qualify for a Policy Adjustment described in subsections (f)(1) through (f)(3), the policy adjustment factor is 1.0.

g) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:

1) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider

for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2124 and 413.170 (1994). This rate will be the rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).

2) Payment for Non-routine Services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3), but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.50, and 140.75 through 140.481, respectively.

3) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.

h) Updates to EAPG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed.

i) Definitions

"Aggregate ancillary cost-to-charge ratio" means the ratio of each hospital's total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

"Consolidation factor" means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation flag or Clinical Procedure Consolidation flag by the EAPG grouper under default EAPG settings.

"Default EAPG settings" means the default EAPG grouper options in 3M's Core Grouping Software for each EAPG grouper version.

"EAPG" means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

"EAPG grouper" means the most recently released version of the EAPG software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during with the discharge occurred; except, for the calendar year beginning January 1, 2014, EAPG grouper means version 3.7 of the EAPG software.

"EAPG PPS" means the EAPG prospective payment system as described in this Section.

"EAPG weighting factor" means, for each EAPG, the product, rounded to the nearest ten-thousandth, of:

the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper; and

the Illinois experience adjustment.

"Estimated cost of outpatient base period claims data" means the product of:

outpatient base period paid claims data total covered charges;

the critical access hospital's aggregate ancillary cost-to-charge ratio; and

a rate year cost inflation factor.

"High outpatient volume" means the number paid outpatient services described in subsection (b)(1) provided during the high volume outpatient base period paid claims data.

"High volume outpatient base period paid claims data" means SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015 and 2016. For subsequent dates of service, the term means the SFY ending 30 months prior to the beginning of the calendar year during which the service is provided.

"Illinois experience adjustment" means, for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to

3M EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

"Labor-related share" means that portion of the statewide standardized amount that is allocated in the EAPG PPS methodology to reimburse the costs associated with personnel. The labor-related share for a hospital is 0.60.

"Mean regional high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within a region, based on outpatient base period paid claims data.

"Mean statewide high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(1)(A) through (D), provided by hospitals within the state, based on outpatient base period paid claims data.

"Medicare IPPS wage index" means the wage index used for inpatient reimbursement as described in 89 Ill. Adm. Code 149.100.

"Non-labor share" means the difference resulting from the labor-related share being subtracted from 1.0.

"Outpatient base period paid claims data" means SFY 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in SFY 2015, 2016 and 2017; for subsequent dates of service, the term means the most recently available adjudicated 12 months of outpatient paid claims data to be identified by the Department.

"Outpatient crossover paid claims data" means SFY 2011 outpatient Medicaid/Medicare dual eligible fee-for-service paid claims data, excluding renal dialysis claims and therapy claims, for EAPG PPS payment for services provided in SFY 2015, 2016 and 2017; for subsequent dates of service, the term means most recently available adjudicated 12-months of outpatient paid claims data to be identified by the Department.

"Packaging factor" means a factor of 0 percent applicable for services designated with a Packaging flag by the EAPG grouper under default EAPG settings plus EAPG 430 (CLASS I CHEMOTHERAPY DRUGS), EAPG 435 (CLASS I PHARMACOTHERAPY), EAPG 495 (MINOR CHEMOTHERAPY DRUGS), EAPG 496 (MINOR PHARMACOTHERAPY), and EAPGs 1001-1020 (DURABLE MEDICAL EQUIPMENT LEVEL 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.

"Rate year cost inflation factor" means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMMS input price index levels from the midpoint of SFY 2011 to SFY 2015.

"Region" means, for a given hospital, the rate region, as defined in 89 Ill. Adm. Code 140.Table J, within which the hospital is located.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

~~b) Ambulatory Procedure Listing (APL)~~
~~Effective July 1, 2012, the Department will reimburse hospitals for certain hospital outpatient procedures as described in subsection (b)(1) of this Section.~~

~~1) APL Groupings~~
~~Under the APL, a list was developed that defines those technical procedures that require the use of the hospital outpatient setting, its technical staff or equipment. These procedures are separated into separate groupings based upon the complexity and historical costs of the procedures. The groupings are as follows:~~

~~A) Surgical Groups~~

~~i) Surgical group 1(a) consists of intense surgical procedures. Group 1(a) surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills~~

~~and highly technical operating room personnel using high technology equipment. The rate for this surgical procedure group shall be $1,794.00.~~

~~ii)~~ ~~Surgical group 1(b) consists of moderately intense surgical procedures. Group 1(b) surgeries generally require the use of an operating room suite or an emergency room treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate for this surgical procedure group shall be $1,049.00.~~

~~iii)~~ ~~Surgical group 1(c) consists of low intensity surgical procedures. Group 1(c) surgeries may be done in an operating suite or an emergency room and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this surgical procedure group shall be $752.00.~~

~~iv)~~ ~~Surgical group 1(d) consists of surgical procedures of very low intensity. Group 1(d) surgeries may be done in an operating room or emergency room, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. Certain dental procedures performed by dentists are included in this group. In order for a dental procedure to be eligible for reimbursement in the outpatient setting, the following criteria must be met: patient requires general anesthesia or conscious sedation; patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to, cardiopulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or the patient cannot be safely managed in an office setting because of behavioral, developmental, or mental disorder. The rate for this surgical procedure group shall be $287.00.~~

~~B)~~ ~~Diagnostic and Therapeutic Groups~~

~~i)~~ ~~Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. Group 2(a) procedures are typically invasive and must be administered by a physician. The rate for this surgical procedure group shall be $941.00.~~

~~ii)~~ ~~Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. Group 2(b) procedures typically include radiological consultation or a diagnostic study. The rate for this procedure group shall be $304.00.~~

~~iii)~~ ~~Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. Group 2(c) procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate for this procedure group shall be $176.00.~~

~~iv)~~ ~~Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. Group 2(d) procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate for this procedure group shall be $136.00.~~

~~C)~~ ~~Group 3 reimbursement for services provided in a hospital emergency department will be made in accordance with one of the three levels described in this Section. Emergency Services mean those services that are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based upon the~~

~~circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.~~

~~i)~~ ~~Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries that pose an immediate significant threat to life or physiologic function or requires an intense level of physician or nursing intervention. An "intense level" is defined as more than two hours of documented one-on-one nursing care or interactive treatment. The rate for this service shall be $181.00.~~

~~ii)~~ ~~Emergency Level II refers to Emergency Services that do not meet the definition in this Section of Emergency Level I care, but that are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity. The rate for this service shall be $67.00.~~

~~iii)~~ ~~Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Level I or II stated in this Section. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The rate for this service shall be $26.00.~~

~~D)~~ ~~Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting that provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories:~~

~~i) for at least 60 minutes but less than six hours and 31 minutes of services, the rate shall be $74.00;~~

~~ii) for at least six hours and 31 minutes but less than 12 hours and 31 minutes of services, the rate shall be $222.00; or~~

~~iii) for at least 12 hours and 31 minutes or more of services, the rate shall be $443.00.~~

~~E) Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse, at different rates, Type A and Type B Psychiatric Clinic Services, as defined in Section 148.40(d)(1). A different rate will also be reimbursed to children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).~~

~~i) The rate for Type A psychiatric clinic services shall be $68.00.~~

~~ii) The rate for Type A psychiatric clinic services provided by a Children's Hospital shall be $102.00.~~

~~iii) The rate for Type B psychiatric clinic services shall be $101.00.~~

~~iv) The rate for Type B psychiatric clinic services provided by a Children's Hospital shall be $102.00.~~

~~F) Effective July 1, 2012, subject to 89 Ill. Adm. Code 152.100, Group 6 for physical rehabilitation services shall no longer be in effect and outpatient physical rehabilitation services provided by a hospital shall be reimbursed through the non-institutional payment system, but will be reimbursed as a hospital service at the following rates of reimbursement:~~

~~i) The rate for rehabilitation services provided by a hospital~~

~~enrolled with the Department to provide outpatient physical rehabilitation shall be $130.00.~~

~~ii) The rate for rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation shall be $115.00.~~

~~iii) The rate for rehabilitation services provided by children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3)(A), shall be $130.00.~~

~~2) Each of the groups described in subsection (b)(1) of this Section will be reimbursed by the Department considering the following:~~

~~A) The Department will provide cost outlier payments for specific devices and drugs associated with specific APL procedures. Such payments will be made if:~~

~~i) The device or drug is on an approved list maintained by the Department. In order to be approved, the Department will consider requests from medical providers and shall base its decision on medical appropriateness of the device or drug and the costs of such device or drug; and~~

~~ii) The provision of such devices or drugs is deemed to be medically appropriate for a specific client, as determined by the Department's physician consultants.~~

~~B) Additional payment for such devices or drugs, as described in subsection (b)(2)(A) of this Section, will require prior authorization by the Department unless it is determined by the Department's professional medical staff that prior authorization is not warranted for a specific device or drug. When such prior authorization has been denied for a specific device or drug, the decision may be appealed as allowed by 89 Ill. Adm. Code 102.80(a)(7) and in accordance with the provisions for assistance appeals at 89 Ill. Adm. Code 104.~~

~~C) The amount of additional payment for devices or drugs, as~~

~~described in subsection (b)(2)(A) of this Section, will be based on the following methodology:~~

~~i) The product of a cost to charge ratio that, in the case of cost reporting hospitals as described in Section 148.130(d), or in the case of other non-cost reporting providers, equals 0.5 multiplied by the provider's total covered charges on the qualifying claim, less the APL payment rate multiplied by four;~~

~~ii) If the result of subsection (b)(2)(C)(i) of this Section is less than or equal to zero, no additional payment will be made. If the result is greater than zero, the additional payment will equal the result of subsection (b)(2)(C)(i) of this Section, multiplied by 80 percent. In such cases, the provider will receive the sum of the APL payment and the additional payment for such high cost devices or drugs.~~

~~D) For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amounts described in subsection (b)(1) of this Section multiplied by a factor of 2.72.~~

~~E) Reimbursement rates for hospitals not required to file an annual cost report with the Department may be lower than those listed in this Section.~~

~~F) Reimbursement for each APL group described in this subsection (b) shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician providing direct patient care who is salaried by the hospital; chemotherapy services provided in conjunction with radiation therapy services; and physical rehabilitation, occupational or speech therapy services provided in conjunction with any APL group described in this~~

~~subsection (b). For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.~~

~~3) The assignment of procedure codes to each of the reimbursement groups in subsections (b)(1)(A) through (b)(1)(E) of this Section are detailed in the Department's Hospital Handbook and in notices to providers.~~

~~4) A one-time fiscal year 2000 payment will be made to hospitals. Payment will be based upon the services, specified in this Section, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the Department and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000, excluding services for Medicare/Medicaid crossover claims and claims that resulted in a zero payment by the Department. A one-time amount of:~~

~~A) $27.75 will be paid for each service for procedure code W7183 (Psychiatric clinic Type A for adults).~~

~~B) $24.00 will be paid for each service for APL Group 5 (Psychiatric clinic Type A only) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).~~

~~C) $15.00 will be paid for each service for APL Group 6 (Physical rehabilitation services) provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).~~

~~5) County Facility Outpatient Adjustment~~

~~A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient adjustment payment. This adjustment payment shall be in addition~~

~~to the amounts calculated under this Section and are calculated as follows:~~

~~i) Beginning with July 1, 1995, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.~~

~~ii) The payment calculated under this subsection (b)(5)(A) may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~

~~iii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.~~

~~B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:~~

~~i) "Base Year" means the most recently completed State fiscal year.~~

~~ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.~~

~~iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.~~

~~iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid~~

~~claims data multiplied by the hospital's cost-to-charge ratio.~~

~~6)~~ ~~Critical Access Hospital Rate Adjustment~~
~~Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485.subpart F shall be eligible for an outpatient rate adjustment for services identified in subsections (b)(1)(A) through (b)(1)(F), excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:~~

~~A)~~ ~~An annual distribution factor shall be calculated as follows:~~

~~i)~~ ~~The numerator shall be $33 million.~~

~~ii)~~ ~~The denominator shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance with 89 Ill. Adm. Code 148.115, less the RY 2011 Rural Adjustment Outpatient Payments calculated in accordance with 89 Ill. Adm. Code 148.115, plus the annual outpatient supplemental payment calculated in accordance with 89 Ill. Adm. Code 148.456.~~

~~B)~~ ~~Hospital Specific Adjustment Value~~
~~For each hospital qualified under this subsection (b)(6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection (b)(6)(A)(ii) and the distribution factor calculated in subsection (b)(6)(A):~~

~~C)~~ ~~Effective for dates of service on or after July 1, 2012, the final APL Rate Adjustment Values shall be the quotient of:~~

~~i)~~ ~~The hospital specific adjustment value identified in subsection (b)(6)(B) divided by~~

~~ii)~~ ~~The total outpatient services identified in subsections (b)(1)(A) through (b)(1)(E), excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the Department's paid claims database as of December 31, 2010.~~

~~D)~~ ~~Non-State Government Owned Provider Adjustment~~
~~Final APL rates for hospitals identified in non-State government owned or operated providers in the State's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.~~

~~E)~~ ~~Applicability~~
~~The rates calculated in accordance with subsection (b)(6)(A) shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.~~

~~i)~~ ~~For State fiscal year 2011, the rate year shall begin January 1, 2011 and end June 30, 2011.~~

~~ii)~~ ~~For State fiscal year 2012 and beyond, the rate year shall be for dates of services beginning July 1 through June 30 of the subsequent year.~~

~~iii)~~ ~~For purposes of this adjustment, a children's hospital identified in Section 149.50(c)(3)(B) shall be combined with the corresponding general acute care parent hospital.~~

~~iv)~~ ~~Beginning with State fiscal year 2012 and each subsequent State fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.~~

~~7)~~ ~~No Year-End Reconciliation~~
~~With the exception of the retrospective rate adjustment described in subsection (b)(9) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).~~

~~8)~~ ~~Rate Adjustments~~
~~With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(5) of this Section shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

~~A) The reimbursement rates described in subsection (b)(5) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~

~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~9) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.~~

~~10) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~

~~e) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:~~

~~1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.~~

~~2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40(c)(2) or (c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate that will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 413.170 (1994).~~

~~3) Payment for non-routine services. For services that are provided during outpatient or home dialysis treatment pursuant to Section 148.40(c)(2) or (c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.~~

~~4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.~~

~~5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

~~A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~

~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~6) With the exception of the retrospective rate adjustment described in subsection (c)(5) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).~~

~~7) Hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B) of this Section shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~

~~8) Effective July 1, 2013, hospitals and freestanding chronic dialysis centers will receive an add-on payment of $60 per treatment day to the rate described in subsection (c)(2) for outpatient renal dialysis treatments or~~

~~home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/ Medicare crossovers) and excluding services provided under Subpart D: State Chronic Renal Disease Program, as defined in Sections 148.600 through 148.640.~~

~~d) Non Hospital-Based Clinic Reimbursement~~

~~1) County-Operated Outpatient Facility Reimbursement~~
~~Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as either a Maternal and Child Health Program managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), or as a Critical Clinic Provider, as described in subsection (e) of this Section, shall be on an all-inclusive per encounter rate basis as follows:~~

~~A) Base Rate. The per encounter base rate shall be calculated as follows:~~

~~i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.~~

~~ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.~~

~~iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) of this Section to determine the per encounter base rate.~~

~~iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) of this Section, shall be the per encounter base rate.~~

~~B) Supplemental Rate~~

~~i) The supplemental service cost shall be divided by the total~~

~~number of direct staff encounters to determine the direct supplemental service cost per encounter.~~

~~ii)~~ ~~The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.~~

~~iii)~~ ~~The quotient derived in subsection (d)(1)(B)(i) of this Section shall be added to the product derived in subsection (d)(1)(B)(ii) of this Section, to determine the per encounter supplemental rate.~~

~~iv)~~ ~~The resulting sum, as described in subsection (d)(1)(B)(iii) of this Section, shall be the per encounter supplemental rate.~~

~~C)~~ ~~Final Rate~~

~~i)~~ ~~The per encounter base rate, as described in subsection (d)(1)(A)(iv) of this Section, shall be added to the per encounter supplemental rate, as described in subsection (d)(1)(B)(iv) of this Section, to determine the per encounter final rate.~~

~~ii)~~ ~~The resulting sum, as determined in subsection (d)(1)(C)(i) of this Section, shall be the per encounter final rate.~~

~~iii)~~ ~~The per encounter final rate, as described in subsection (d)(1)(C)(ii) of this Section, shall be adjusted in accordance with subsection (d)(2) of this Section.~~

~~2)~~ ~~Rate Adjustments~~
~~Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) of this Section, shall be calculated as follows:~~

~~A)~~ ~~The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) and (e)(2) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by~~

~~the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~C) The final rate described in subsection (d)(1)(C) of this Section shall be no less than $147.09 per encounter.~~

~~3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).~~

~~4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) that pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.~~

~~e) Critical Clinic Providers~~

~~1) Effective for services provided on or after September 27, 1997, a clinic owned or operated by a county with a population of over three million, that is within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection (e) require that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:~~

~~A) 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,~~

~~B) 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,~~

~~C) 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,~~

~~D) 3600 for reimbursement provided during the facility's cost reporting year ending during 2001, and~~

~~E) 4200 for reimbursement provided during the facility's cost reporting year ending during 2002.~~

~~2) Reimbursement for all services provided by any Critical Clinic Provider shall be on an all-inclusive per-encounter rate that shall equal reported direct costs of Critical Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.~~

~~3) Critical Clinic Providers, as described in this subsection (e), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (e).~~

~~4) The reimbursement rates described in this subsection (e) shall be no less than the reimbursement rates in effect on July 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~f) Critical Clinic Provider Pharmacies~~
~~Prescribed drugs, dispensed by a pharmacy that is a Critical Clinic Provider, that~~

~~are not part of an encounter reimbursable under subsection (e) of this Section shall be reimbursed at the rate described in subsection (e)(2) of this Section.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.150 Public Law 103-66 Requirements

Effective for dates of service on or after July 1, 2014:

a) All cost reporting hospitals ~~deemed eligible to receive disproportionate share hospital (DSH) adjustment payments, in accordance with Section 148.120,~~ are required~~, and non-DSH cost reporting hospitals are encouraged,~~ to ~~annually~~ submit annually, on or before August 15 of the rate year in a form or format specified by the Department, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:

1) The dollar amount of Illinois Medicaid charges rendered in the base year.

2) The dollar amount of hospital charity care charges rendered in the base year for uninsured patients.

3) The dollar amount of hospital bad debt, less any recoveries, rendered in the base year for uninsured patients.

4) The dollar amount of Illinois total hospital charges for care rendered in the base year.

b) Definitions

1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.

2) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.

3) "Base year" means the hospital's cost reporting period, utilized in the current rate year disproportionate share determination, and as described in Section 148.120(i)~~(k)~~(1).

4) "Hospital charity care charges" and "hospital bad debt" mean inpatient, outpatient and hospital clinic services provided to individuals without health insurance or other sources of third party coverage. For purposes of the previous statement in this subsection (b)(4), State or unit of local government payments made to a hospital on behalf of indigent patients ~~(i.e., Transitional Assistance and State Family and Children Assistance)~~ is ~~shall~~ not ~~be~~ considered to be a form of insurance or a source of third-party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included. Charity care charges and bad debt cannot include unpaid co-pays or third party obligations of insured patients, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act (42 USC 291).

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.160 Payment Methodology for County-Owned Large Public Hospitals ~~in an Illinois County with a Population of Over Three Million~~

a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)~~(c)(8)~~, county-owned hospitals, as defined in Section 148.25(a)(1),~~an Illinois county with a population greater than three million~~ are excluded from the DRG PPS for reimbursement for inpatient hospital services and are reimbursed on a per diem basis~~in accordance with this Section~~.

1) Inpatient Per Diem Rate Calculation
County-owned hospital inpatient per diem rates are calculated as follows:

A) Each county-owned hospital's inpatient base year costs, including operating capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.

B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by Centers for Medicare and Medicaid Services (CMMS).

C) Calculate the sum of:

i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

ii) Total uncovered Medicare crossover claim cost in the inpatient base period claims data.

D) The inpatient per diem rate shall be the quotient of:

i) Combined inflated base year cost and uncovered Medicare crossover claims cost, per subsection (a)(1)(C); and

ii) Total hospital base year covered days, excluding non-Medicare crossover claims, in the inpatient base period claims data.

E) The inpatient per diem rates shall be reduced if resulting payments exceed available Department funding or the CMMS Upper Payment Limit.

2) Rate Updates
County-owned hospital per diem rates shall be updated on an annual basis using more recent inpatient base period claims data, Medicare cost report data and cost inflation data.

3) New hospitals, for which inpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the per diem rate calculated in subsection (a)(1).

4) Review Procedure

The review procedure shall be in accordance with Section 148.310.

b) Outpatient Reimbursement Methodology
Large public hospitals, as defined in Section 148.25(a), are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Section 148.140, and are to receive provider-specific EAPG standardized amounts.

1) Outpatient EAPG Standardized Amount Calculation
County-owned hospital outpatient EAPG standardized amounts are calculated as follows:

A) Each county-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMMS.

C) EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.

D) EAPG standardized amounts shall be reduced if resulting payments exceed available HFS funding or the CMMS Upper Payment Limit.

2) Rate Updates and Adjustments

A) County-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data, and costs inflation data.

B) Restructuring Adjustments

Adjustments to outpatient base year costs, as described in subsection (b)(1), will be made to reflect restructuring since filing the base year costs reports. The restructuring must have been mandated to meet State, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, (1982)) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring cost must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available cost reports to determine restructuring costs.

3) New hospitals, for which outpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the EAPG standardized amount calculated in subsection (b)(1).

4) Review Procedure
The review procedure shall be in accordance with Section 148.320.

c) Definitions

"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the SFY ending 24 months prior to the beginning of the rate period.

"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the SFY ending 24 months prior to the beginning of the rate period.

"Rate period" means the SFY for which the county-owned hospital inpatient and outpatient rates are effective.

~~b) Base Year Costs~~

~~1) The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 20 and 31 months prior to the fiscal~~

~~year for which rates are being set.~~

~~2)~~ ~~The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~

~~3)~~ ~~The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) of this Section.~~

~~4)~~ ~~The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3) of this Section.~~

~~5)~~ ~~New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) of this Section and inflated in subsection (d)(1) of this Section.~~

~~e)~~ ~~Restructuring Adjustments~~
~~Adjustments to the base year cost per diem, as described in subsection (b)(4) of this Section, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance, between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data~~

~~Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) of this Section.~~

~~d) Inflation Adjustment For Base Year Cost Report Inflator~~

~~1) The base year cost per diem, as defined in subsection (b)(4) of this Section, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) of this Section by the previous year's operating cost per diem.~~

~~2) Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.~~

~~3) Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (d)(1) and (2) of this Section that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~

~~e) Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~

~~f) Applicable Inpatient Adjustments~~

~~1) The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS, as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~

~~2) The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in subsection (a) of this Section are described in this Section.~~

~~A)~~ ~~The payment adjustment shall be $150 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate, as described in Section 148.120(k)(5), exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.~~

~~B)~~ ~~The amount calculated pursuant to subsection (f)(2)(A) of this Section shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:~~

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

~~ii)~~ ~~The percentage increase in the statewide average hospital payment rate, as described in Section 148.120(k)(8) over the previous year's statewide average hospital payment rate.~~

~~C)~~ ~~The amount calculated pursuant to subsections (f)(2)(A) through (f)(2)(B) of this Section shall be no less than the rate calculated in accordance with Section 148.120(g)(2) in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~D)~~ ~~Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~

~~E)~~ ~~The amount calculated pursuant to subsection (f)(2) of this Section~~

~~shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

~~3) County Provider Adjustment.~~

~~A) Effective July 1, 1995, hospitals reimbursed under this Section shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:~~

~~i) Beginning with July 1, 1995, hospitals under this Section shall receive $15,500 per Medicaid inpatient admission in the base period.~~

~~ii) The payments calculated under this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments.~~

~~iii) The payments made under this subsection shall be made on a quarterly basis.~~

~~B) County Provider Adjustment Definitions.~~

~~i) "Base Period" means State fiscal year 1994.~~

~~ii) "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.~~

~~4) Hospitals reimbursed under this Section shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995,~~

~~supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments as described in Section 148.120 and subsection (f)(2) of this Section, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991 through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient payment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. This minimum may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

~~g) Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.~~

~~h) Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section 148.290(c).~~

~~i) Reductions to Total Payments~~

~~1) Copayments. Copayments are assessed in accordance with Section 148.190.~~

~~2) Third Party Payments. The requirements of Section 148.290(f)(2) shall~~

~~apply.~~

~~j)~~ ~~Prepayment and Utilization Review~~
~~Prepayment and utilization review requirements shall be in accordance with Section 148.240.~~

~~k)~~ ~~Cost Reporting Requirements~~
~~Cost reporting requirements shall be in accordance with Section 148.210.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.170 Payment Methodology for University-Owned Large Public Hospitals ~~Organized Under the University of Illinois Hospital Act~~

Effective for dates of service on or after July 1, 2014:

a) Inpatient Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(b)(5)~~(c)(8)~~, a large public hospital, as defined in Section 148.25(a), is ~~organized under the University of Illinois Hospital Act shall be~~ excluded from the DRG PPS for reimbursement for inpatient hospital services and shall be reimbursed on a per diem basis~~in accordance with this Section~~.

1) Inpatient Per Diem Rate Calculation
University-owned hospital inpatient per diem rates are calculated as follows:

A) Each University-owned hospital's inpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using inpatient base period claims data and Medicare cost report data with reporting periods matching the inpatient base period.

B) The inpatient base year costs shall be inflated from the midpoint of the inpatient base period claims data to the midpoint of the time period, for which rates are being set (rate period) based on an inflation methodology determined by the Department and approved by the Center for Medicare and Medicaid Services (CMMS).

C) Calculate the sum of:

i) The total hospital inflated base year costs, excluding non-Medicare crossover claims, in the inpatient base period claims data; and

ii) Total uncovered Medicare crossover claim cost in the inpatient base period claims data.

D) The inpatient per diem rate shall be the quotient of:

i) Combined inflated base year cost and uncovered Medicare crossover claims cost, per subsection (a)(1)(C); and

ii) Total hospital base year covered days, excluding non-Medicare crossover claims, in the inpatient base period claims data.

E) The inpatient per diem rates shall be reduced if resulting payments exceed available Department funding or the CMMS Upper Payment Limit.

2) Rate Updates and Adjustments
University-owned hospital per diem rates shall be updated on an annual basis using more recent inpatient base period claims data, Medicare cost report data and cost inflation data.

3) New hospitals, for which inpatient base period claims data or Medicare cost reports are not on file, will be reimbursed the per diem rate calculated in subsection (a)(1).

4) Review Procedure
The review procedure shall be in accordance with Section 148.310.

5) Applicable Adjustment for DSH Hospitals
The criteria and methodology for making applicable adjustments to DSH hospitals shall be in accordance with Section 148.120.

b) Outpatient Reimbursement Methodology
Large public hospitals, as defined in Section 148.25(a), are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Section 148.140 and are to receive a provider-specific EAPG standardized amount.

1) Outpatient EAPG Standardized Amount Calculation
University-owned hospital outpatient EAPG standardized amount is calculated as follows:

A) Each University-owned hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

B) The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMMS.

C) EAPG standardized amounts shall be determined for each State-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.

D) EAPG standardized amounts shall be reduced if resulting payments exceed available Department funding or the Centers for Medicare and Medicaid Services Upper Payment Limit.

2) Rate Updates and Adjustments
State-owned hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data and cost inflation data.

3) Review Procedure
The review procedure shall be in accordance with Section 148.310.

c) Definitions

"Inpatient base period paid claims data" means Medicaid fee-for-service inpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.

"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.

"Rate period" means the State fiscal year for which the University-owned hospital inpatient and outpatient rates are effective.

~~b) Base Year Costs~~

~~1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992.~~

~~2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.~~

~~c) Restructuring Adjustment~~
~~Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect~~

~~restructuring cost adjustments. For audited reports received at the Illinois Department of Public Aid, Office of Health Finance, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.~~

~~d) Inflation Adjustment For Base Year Cost Report Inflator~~
~~Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.~~

~~e) Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~

~~f) Applicable adjustments for DSH Hospitals~~

~~1) The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS as described in subsection (a) of this Section, shall be in accordance with Section 148.120.~~

~~2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) of this Section, as adjusted for restructuring, as described in subsection (c) of this Section, and as adjusted for inflation, as described in subsection (d) of this Section, and the calculated disproportionate share per diem payment adjustment, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50 and this amount shall be the supplemental DSH~~

~~payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

~~g)~~ ~~Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.~~

~~h)~~ ~~Reductions to Total Payments~~

~~1)~~ ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~

~~2)~~ ~~Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.~~

~~i)~~ ~~Prepayment and Utilization Review~~
~~Prepayment and utilization review requirements shall be in accordance with Section 148.240.~~

~~j)~~ ~~Cost Reporting Requirements~~
~~Cost reporting requirements shall be in accordance with Section 148.210.~~

~~k)~~ ~~Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act (Repealed)

~~a)~~ ~~The Department shall make supplemental disproportionate share (DSH) payments in accordance with this Section to hospitals that meet all of the following requirements:~~

~~1)~~ ~~Qualify for DSH payment adjustments in accordance with Section~~

~~148.120(a).~~

~~2) Are organized under the Town Hospital Act [60 ILCS 170].~~

~~3) Have entered into an agreement, approved by the Director.~~

~~b) Review Procedure~~
~~The review procedure shall be in accordance with Section 148.310.~~

~~c) Applicable Adjustments for Disproportionate Share Hospitals (DSH)~~

~~1) The criteria and methodology for making applicable adjustments to government owned DSH hospitals as described in subsection (a) above, shall be in accordance with Section 148.120.~~

~~2) Effective with dates of service on or after May 12, 1995, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall be eligible for supplemental DSH payments. Effective with admissions on or after May 12, 1995, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's alternate cost per diem rate in effect on May 12, 1995, as described in Sections 148.260, 148.270, and 89 Ill. Adm. Code 152.200, and the calculated disproportionate share per diem payment adjustment in effect on May 12, 1995, as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payor for the period of August 1, 1991 through July 31, 1992. The resulting product shall be multiplied by 6.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided. The supplemental DSH payments cannot exceed the amount the hospital certifies as costs eligible for Federal Financial Participation under Title XIX of the Social Security Act.~~

~~3) DSH adjustments made under this subsection are subject to the DSH adjustment limitations described in Section 148.120(j).~~

~~d) Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month~~

~~period beginning on October 1 of the year and ending September 30 of the following year, except for the period of May 12, 1995 through September 30, 1995.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.180 Payment for Pre-operative Days and~~,~~ Patient Specific Orders~~, and Services Which Can Be Performed in an Outpatient Setting~~

Effective for dates of service on or after July 1, 2014:

a) Pre-operative Days. For hospitals and distinct part units reimbursed on a per diem basis under Sections 148.105, 148.110, 148.116, 148.160 or~~,~~ 148.170~~ or 148.250 through 148.300~~, payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and must consist of a written notation made by the physician which documents that more than one pre-operative day is medically necessary.

~~b) Inpatient Procedures Requiring Justification~~

~~1) A list of restricted inpatient procedures has been established. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to:~~

~~A) Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes);~~

~~B) The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;~~

~~C) An unrelated procedure is being done simultaneously which itself requires surgical hospitalization;~~

~~D) The practitioner has documented the medical necessity of~~

~~performing the patient's surgery in an inpatient setting;~~

~~E) The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk;~~

~~F) Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting); and~~

~~G) Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:~~

~~i) Instability of vital signs;~~

~~ii) Respiratory distress greater than existed pre-operatively;~~

~~iii) Post-operative pain not relieved by oral medication;~~

~~iv) Uncontrollable bleeding;~~

~~v) Lack of state of consciousness appropriate to age and development;~~

~~vi) Presence of persistent nausea or vomiting; and~~

~~vii) Inability to ambulate consistent with age, previous mobility status and/or procedure.~~

~~2) The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require an inpatient admission are reevaluated periodically.~~

~~3) Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory Committee, representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or~~

~~individuals.~~

b~~e~~) Ancillary Services and Tests

1) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed. Standing orders are not acceptable.

2) Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual x-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; and drugs and pharmaceutical supplies must indicate strength, dosages and durations.

3) Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described in this Section shall result in the disallowance of the applicable charges upon audit.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.200 Alternate Reimbursement Systems (Repealed)

~~a) Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.~~

~~b) Section 148.220 describes the payment methodology for hospital inpatient services to recipients for admissions occurring prior to September 1, 1991.~~

~~c) The payments described in Sections 148.250 through 148.300 shall be effective~~

~~for admissions on and after October 1, 1992, subject to the provisions of Section 148.20(b).~~

~~d) The payments described in Section 148.82 shall be effective for admissions on and after September 1, 1991, with the exception of provisions that relate to pancreas or kidney-pancreas transplants. Provisions relating to pancreas or kidney-pancreas transplants shall be effective for admissions on and after July 1, 1992.~~

~~e) Sections 148.250 through 148.300 describe the payment methodologies for hospital inpatient services to recipients of Medical Assistance provided by a hospital not reimbursed under the DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code Part 149 or the reimbursement methodologies described in Sections 148.82, 148.160 and 148.170.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.210 Filing Cost Reports

Effective for dates of service on or after July 1, 2014:

a) Excepting those operated by an agency of the United States government, all ~~All~~ hospitals in Illinois and ~~, those~~ hospitals in contiguous states providing 100 or more paid acute inpatient days of care to the Illinois Medicaid Program ~~participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)),~~ shall be required to file Medicaid and Medicare cost reports within 150 days after the close of that provider's fiscal year. Any hospital accredited by TJC not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program and census logs by program and financial class. The Bureau of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis.

~~1) Any hospital certified in the Medicare Program (Title XVIII) and electing, for the first time, to be reimbursed under the DRG PPS must include a copy of the two most recently audited Medicare cost reports at the time of enrollment.~~

~~2) Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program, and census logs by program and financial class. The Office of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis. Should the hospital elect not to comply with the audit request, or the financial statements are given other than an unqualified opinion, the hospital will receive an alternate rate as described in Section 148.270.~~

b) No extension of the Medicaid cost report due date will be granted by the Department unless the Centers for Medicare and Medicaid Services (CMMS~~CMS~~) grants an extension of the due date for the related Medicare cost report. Should CMMS~~CMS~~ extend the Medicare cost report due date, the Department will extend the Medicaid and Medicare cost reports due date by an equivalent period of time.

c) If the hospital has not filed the required Medicaid cost reports within 150 days after the close of the hospital's fiscal year, the Department shall suspend payment for covered medical services until the Department receives the required information.

d) The assessment or license fees described in 89 Ill. Adm. Code 140, Subpart C, ~~140.82, 140.84, 140.94 and 140.95~~ may not be reported as allowable Medicaid costs on the Medicaid cost report.

e) Cost Report Reviews
The Bureau of Health Finance shall audit the information shown on the cost reports. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. The request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. The

request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period.

f) Hospitals described in Section 148.25(a)(1) and (a)(2) shall be required to submit outpatient cost reports to the Department within 150 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.220 Pre September 1, 1991, Admissions (Repealed)

~~Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991 will be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.230 Admissions Occurring on or after September 1, 1991 (Repealed)

~~Reimbursement to hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code 149) or the reimbursement methodologies established at Sections 148.82, 148.160 and 148.170 for inpatient admissions occurring on or after September 1, 1991 shall be calculated in accordance with Sections 148.250 through 148.300, subject to the provisions of Section 148.20(b).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

Effective for dates of service on or after July 1, 2014:

a) Utilization Review
The Department, or its designated peer review organization, shall conduct utilization review in compliance with Section 1152 of the Social Security Act and 42 CFR Subchapter F (October 1, 2013~~2001~~). A peer review shall be conducted by a Physician Peer Reviewer who is licensed to practice medicine in all its branches, engaged in the active practice of medicine, board certified or board eligible in his or her specialty and has admitting privileges in one or more Illinois hospitals. Payment will only be made for those admissions and days approved by

the Department or its designated peer review organization. Utilization review may consist of, but not be limited to, preadmission, concurrent, pre-payment, and post-payment reviews to determine, pursuant to 42 CFR 476, Subpart C (October 1, 2013~~2001~~), the following:

1) Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury;

2) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges, including, but not limited to, the coordination of care requirements defined in Section 148.40(a)(10) for the Children's Mental Health Screening, Assessment and Support Services (SASS) Program;

3) Through DRG ~~(Diagnosis Related Grouping) (see 89 Ill. Adm. Code 149)~~ validation, the validity of diagnostic and procedural information supplied by the hospital;

4) The completeness, adequacy and quality of hospital care provided;

5) Whether the quality of the services meets professionally recognized standards of health care; or

6) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type.

b) Notice of Utilization Review
The Department shall provide hospitals with notice 30 days before a service is subject to utilization review, as described in subsections (c), (d), (e) and (f) of this Section, that the service is subject to such review. In determining whether a particular service is subject to utilization review, the Department may consider factors that include:

1) Assessment of appropriate level of care;

2) The service could be furnished more economically on an outpatient basis;

3) The inpatient hospital stays for the service deviate from the norm for inpatient stays using accepted length of stay criteria;

4) The cost of care for the service;

5) Denial rates; and

6) Trends or patterns that indicate potential for abuse.

c) Preadmission Review
Preadmission review may be conducted prior to admission to a hospital to determine if the services are appropriate for an inpatient setting. The Department shall provide hospitals with notice of the criteria used to determine medical necessity in preadmission reviews 30 days before a service is subject to preadmission review.

d) Concurrent Review
Concurrent review consists of a certification of admission and, if applicable, a continued stay review.

1) The certification of admission is performed to determine the medical necessity of the admission and to assign an initial length of stay based on the criteria for the admission. Admissions will be denied for patients ~~age~~ 21 years of age or over who present at a hospital within 60 days after a previous admission for specified alcohol-induced or drug-induced detoxification. The Department will specify to hospitals the lists of affected diagnosis codes via provider releases and postings on the Department's website.

2) The continued stay review is conducted to determine the medical necessity and appropriateness of continuing the inpatient hospitalization. More than one continued stay review can be performed in an inpatient stay.

e) Pre-payment Review
The Department may require hospitals to submit claims to the Department for pre-payment review and approval prior to rendering payment for services provided.

f) Post-payment Review
Post-payment review shall be conducted on a random sample of hospital stays

following reimbursement to the hospital for the care provided. The Department may also conduct post-payment review on specific types of care.

g) Hospital Utilization Control
Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare ~~(Title XVIII)~~ must meet the utilization review plan requirements in 42 CFR~~, Ch. IV, Part~~ 456 (October 1, 2013~~2001~~). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1)~~149.50(c)(1)~~ shall be in accordance with the federal regulations.

h) Denial of Payment as a Result of Utilization Review

1) If the Department determines, as a result of utilization review, that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission, transfer of an individual or failure to comply with the coordination of care requirements of Section 148.40.

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

2) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization, under subsection (h)(1)(A)~~ of this Section~~ as a result of prepayment review, a reconsideration will be provided within 30 days upon the request of a hospital or physician if such request is the result of a medical necessity or appropriateness of care denial determination and is received

within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.

3) When payment with respect to the discharge of an individual patient is denied by the Department or its designated peer review organization under subsection (h)(1)(A) ~~of this Section~~ as a result of a preadmission or concurrent review, the hospital or physician may request an expedited reconsideration. The request for expedited reconsideration must include all the information, including the medical record, needed for the Department or its designated peer review organization to make its determination. A determination on an expedited reconsideration request shall be completed within one business day after the Department's or its designated peer review organization's receipt of the request. Failure of the hospital or physician to submit all needed information shall toll the time in which the reconsideration shall be completed. The results of the expedited reconsideration shall be communicated to the hospital by telephone within one business day and in writing within three business days after the determination.

4) A determination under subsection (h)(1) ~~of this Section~~, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

A) Withholding ~~withholding Medicaid~~ payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) Termination ~~termination~~ of the hospital's Provider Agreement.

i) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under this Part and 89 Ill. Adm. Code 149~~Sections 148.82, 148.120, 148.130, 148.150, 148.160, 148.170, 148.175 and 148.250 through 148.300~~ are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (i)(1)(B)(i) through (i)(1)(B)(v) ~~of this Section~~.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

i) A physician whose salary is included in the hospital's cost report for direct patient~~ care may not bill separately on a fee-for-service basis~~.

ii) A teaching physician who provides direct patient care, ~~may not bill separately on a fee-for-service basis~~ if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

i) A physician whose salary is not included in the hospital's cost report for direct patient care~~ may bill separately on a fee-for-service basis~~.

ii) A teaching physician who provides direct patient care, ~~may bill separately on a fee-for-service basis~~ if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident, ~~may bill separately on a fee-for-service basis~~ when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, ~~may bill separately on a fee-for-service basis~~ when, by the terms of his or her contract with the hospital, he or she may charge for professional services and does~~do~~, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a nonteaching administrative or staff

position in a hospital or medical school, ~~may bill separately on a fee-for-service basis~~ to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

j) "Designated peer review organization" means an organization designated by the Department that is experienced in utilization review and quality assurance, which meets the guidelines in Section 1152 of the Social Security Act and 42 CFR 475 (2013~~October 1, 2001~~).

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals (Repealed)

~~The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:~~

~~a) allowable operating cost per diem;~~

~~b) capital costs reimbursed on a per diem basis;~~

~~c) applicable DSH adjustments as described in Section 148.120 and outlier adjustments as described in Section 148.130; and~~

~~d) applicable trauma center adjustments, as described in Section 148.290(c), and Medicaid high volume adjustments, as described in Section 148.290(d).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates (Repealed)

~~a) Calculation for the first rate year period~~

~~1) Allowable operating cost per diem~~

~~A) The allowable operating cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period defined in Section 148.25(g)(1) divided by the hospital's Medicaid inpatient days.~~

~~B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:~~

~~i) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.~~

~~ii) Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

~~iii) These two trended operating costs per diem are then added together and divided by two.~~

~~iv) The average operating cost per diem calculated in subsection (a)(1)(B)(iii) above is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect ninety days prior to the admission in order to calculate the hospitals final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.~~

~~2) Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

~~A) These two trended capital related costs per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~

~~B) The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~

~~C) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.~~

~~3) Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

~~A) The two trended direct medical education costs per diem are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.~~

~~B) The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.~~

~~C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in~~

~~subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.~~

~~b) Calculation for Subsequent Rate Periods~~

~~1) For the rate period described in Section 148.25(g)(2)(A), the final rate per diem shall be determined by taking the operating, capital and direct medical education trended rate costs per diems calculated under subsection (a) of this Section and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).~~

~~2) For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem shall be determined by:~~

~~A) Adding the operating and capital trended rate cost per diems calculated under subsection (a) of this Section that were in effect on June 30, 1993;~~

~~B) Updating the trended rate cost per diems described in subsection (b)(2)(A) above;~~

~~i) In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and~~

~~ii) In the case of a hospital described in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), or (c)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEFRA price inflation factor.~~

~~c) Rebasing~~
~~For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section~~

~~148.25(g)(1).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals (Repealed)

~~a) Calculation of Alternate Cost Per Diem Rates for All Hospitals~~
~~For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1).~~

~~b) Calculation of Payment Rates for Certain Exempt Hospital Units~~

~~1) For admissions occurring within the rate period described in Section 148.25(g)(2)(A):~~

~~A) In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.~~

~~B) The resulting quotient, as calculated in subsection (b)(1)(A), shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).~~

~~C) The capital related cost per diem, as calculated in Section 148.260(a)(2), is then added to the resulting product calculated in subsection (b)(1)(B), subject to the inflation adjustment described in Section 148.260(c)(1).~~

~~D) Subject to the provisions of subsections (b)(1)(E) and (b)(1)(F), the final distinct part unit payment rate shall be the lower of:~~

~~i) The result of the calculations described in subsections (b)(1)(A) through (b)(1)(B); or~~

~~ii) The hospital's alternate cost per diem rate, as calculated in subsection (a) of this Section.~~

~~E) In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.~~

~~F) In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.~~

~~2) For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1), updated to the midpoint of the current rate period, using the TEFRA price inflation factor.~~

~~c) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g., a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:~~

~~1) For general acute-care hospitals, reimbursement for inpatient services:~~

~~A) provided by Illinois general acute care hospitals prior to July 1, 2007 shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~

~~B) provided by Illinois general acute care hospitals on or after July 1, 2007 shall be reimbursed at either of the following:~~

~~i) utilizing the payment methodologies described in 89 Ill. Adm. Code 149 that will only reflect the federal/regional~~

~~blended rate described in 89 Ill. Adm. Code 149.100 and a capital rate equal to one standard deviation above the mean capital rate, as determined in 89 Ill. Adm. Code 149.150(c), for all providers reimbursed under the same federal/regional blended rate; or~~

~~ii) at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~

~~C) provided by out of state general acute care hospitals shall be at the average payment rate calculated under subsection (a) or (b), as applicable, for those hospitals that would otherwise be reimbursed under 89 Ill. Adm. Code 149.~~

~~2) For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(1):~~

~~A) for services provided by a psychiatric hospital that began operation on or after January 1, 2008, that is devoted exclusively to the care of individuals who have not attained 19 years of age, reimbursement for inpatient psychiatric services shall be at the arithmetic mean of the rates defined in subsections (c)(2)(B) and (c)(5)(A) of this Section.~~

~~B) for all other psychiatric hospitals, reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).~~

~~3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).~~

~~4) For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).~~

~~5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services:~~

~~A) provided before August 1, 1998, shall be at the average rate calculated under subsection (a) for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3);~~

~~B) provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Section 148.280 for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined from the hospital's fiscal year 1994 cost report.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Repealed)

~~a) Children's Hospitals~~

~~1) Initial Rate Period~~

~~A) For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), are grouped into one peer group.~~

~~B) Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.~~

~~C) These base period costs shall be updated, trended forward from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set, according to the methodology of the national total hospital market basket price proxies, (DRI).~~

~~D) The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's~~

~~median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.~~

~~2) Subsequent Rate Periods~~
~~For the rate period beginning on October 1, 1992, as described in Section 148.25(g)(1)(A), and for subsequent rate periods, as described in Section 148.25(g)(1)(B), the initial rate, as calculated under subsection (a)(1) above, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).~~

~~b) Hospitals Reimbursed Under Special Arrangements~~
~~Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections 148.40(e) through 148.40(g).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.290 Adjustments and Reductions to Total Payments

Effective for dates of service on or after July 1, 2014:

a) The adjustments described in this Section, as applicable, shall be made to reimbursement amounts calculated pursuant to Sections 148.105, 148.110, 148.115, 148.140, 148.160, 148.170, 148.330 and 89 Ill. Adm. Code 149.100 prior to payment. The adjustments are to be applied in the order in which they are listed in this Section.

b) Adjustments to base rates made pursuant to 89 Ill. Adm. Code 152.150.

c) Increases in Payments. Supplemental payments pursuant to the Long Term Acute

Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155] in accordance with Section 148.115(f).

d) Reductions in Payments. The Department's payment obligation shall be reduced by:

1) Charges. Except for reimbursement calculated under Sections 148.140, 148.160 and 148.170, payment shall not exceed the lesser of:

A) The reimbursement amount determined pursuant to subsections (a) and (b).

B) The allowable charges billed to the Department on the claim.

2) Hospital Rate Reductions. Payment shall be reduced pursuant to the provisions of 89 Ill. Adm. Code 152.100.

3) Third-party Liability. Hospitals shall determine whether services are covered, in whole or in part, under any program or under any other private group indemnification or insurance program or managed care entity. To the extent that coverage is available, the Department's payment obligation shall be reduced.

4) Copayments. Copayments are assessed in accordance with Section 148.190.

e) Increases in Payments. The Department's payments obligations shall be increased, if applicable, by:

1) Medicaid high volume adjustment payments pursuant to Section 148.112.

2) Medicaid percentage adjustment payments pursuant to Section 148.122.

3) DSH adjustment payments pursuant to Section 148.120.

~~a) Applicable Adjustments for DSH~~
~~The criteria and methodology for making applicable DSH adjustments to hospitals shall be in accordance with Section 148.120.~~

~~b) Outlier Adjustments~~
~~Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code 149).~~

~~c) County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:~~

~~1) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) of this Section) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.~~

~~2) The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.~~

~~3) The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.~~

~~4) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in subsection (c) of this Section. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.~~

~~5) Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) of this Section are as follows:~~

~~A)~~ ~~"Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.~~

~~B)~~ ~~"Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under 18 years of age.~~

~~C)~~ ~~"TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.~~

~~D)~~ ~~"TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending~~

~~September 30 of the following year.~~

~~E)~~ ~~"Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by subsection (c)(4) of this Section.~~

~~d)~~ ~~Medicaid High Volume Adjustments (MHVA)~~

~~1)~~ ~~For inpatient admissions occurring on or after October 1, 2003 , the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that meet the following criteria:~~

~~A)~~ ~~Be eligible to receive the adjustment payments described in Section 148.122 in the MHVA rate period; and~~

~~B)~~ ~~Not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B) in the MHVA rate period.~~

~~2)~~ ~~Calculation of Medicaid High Volume Adjustments~~

~~A)~~ ~~Hospitals meeting the criteria specified in subsection (d)(1) of this Section shall receive a MHVA payment adjustment of $60.~~

~~B)~~ ~~For children's hospitals, as defined in Section 148.122 (a)(5), the payment adjustment calculated under subsection (d)(2)(A) of this Section shall be multiplied by 2.0.~~

~~C)~~ ~~The amount calculated pursuant to subsections (d)(2)(A) and (d)(2)(B) of this Section shall be adjusted by the aggregate annual increase in the national hospital market price proxies (DRI) hospital cost index (Health Care Cost Review, published by Global Insight, 24 Hartwell Avenue, Lexington MA (2003). This~~

~~incorporation by reference includes no later amendments or editions.) from the MHVA rate period 1993, as defined in Section 148.290(d)(4)(B), through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of:~~

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

~~ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (d)(4)(C) of this Section, over the previous year's statewide average hospital payment rate.~~

~~D) The adjustments calculated under subsections (d)(2)(A) through (d)(2)(C) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.~~

~~3) Medicaid High Volume Adjustment Limitations.~~
~~Hospitals that qualify for MHVA adjustments under subsections (d)(2)(A) through (d)(2)(C) of this Section shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a Medicaid Percentage Adjustment hospital, as required by subsection (d)(1) of this Section. In this instance, the annual adjustment described in subsections (d)(2)(A) through (d)(2)(C) of this Section shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for Medicaid percentage adjustment payments, under Section 148.122, by the Department.~~

~~4) Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (d) of this Section are as follows:~~

~~A) "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.~~

~~B) "MHVA rate period" means, beginning October 1, 1993, the 12~~

~~month period beginning on October 1 of the year and ending September 30 of the following year.~~

~~C)~~ ~~"Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).~~

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

~~f)~~ ~~Reductions to Total Payments~~

~~1)~~ ~~Copayments. Copayments are assessed in accordance with Section 148.190.~~

~~2)~~ ~~Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.295 Critical Hospital Adjustment Payments ~~(CHAP)~~

Effective for dates of service on or after July 1, 2014, except those Sections specifically designated otherwise, Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25(a)~~(b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B),~~ for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section. For a hospital that is located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the

Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 no new payment or rate increase that would otherwise become effective for dates of service on or after July 1, 2010 shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care Program.

~~a) Trauma Center Adjustments (TCA)~~
~~The Department shall make a TCA to hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (DPH) in accordance with the provisions of subsections (a)(1) through (a)(4) of this Section. For the purpose of a TCA, a children's hospital, as defined under 89 Ill. Adm. Code 149.50(c)(3), operating under the same license as a hospital designated as a trauma center, shall be deemed to be a trauma center.~~

~~1) Level I Trauma Center Adjustment.~~

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

~~B) Adjustment. Hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:~~

~~i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $21,365 per Medicaid trauma admission in the CHAP base period.~~

~~ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $14,165 per Medicaid trauma admission in the CHAP base period.~~

~~2) Level I Trauma Center Adjustment for hospitals located in the same city that alternate their Level I trauma center designation.~~

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

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

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

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

~~i) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of $5,250 per Medicaid trauma admission for that class, in the CHAP base period.~~

~~ii) If the sum of Medicaid trauma center admissions within either class, as described in subsection (a)(2)(A), is less than the mean Medicaid trauma admissions of the 2 classes under subsection (a)(2)(A) of this Section, then each member of that class shall receive an adjustment of $3,625~~

~~per Medicaid trauma admission for that class in the CHAP base period.~~

~~3) Level II Rural Trauma Center Adjustment. Rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565 per Medicaid trauma admission in the CHAP base period.~~

~~4) Level II Urban Trauma Center Adjustment. Urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $11,565 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:~~

~~A) The hospital is located in a county with no Level I trauma center; and~~

~~B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(4) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(4) of this Section; and~~

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

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

~~b) Rehabilitation Hospital Adjustment (RHA)~~

~~Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission (previously known as the Joint Committee on Accreditation of Healthcare Organizations), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following four components:~~

~~1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive $4,215 per Medicaid Level I rehabilitation admission in the CHAP base period.~~

~~2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:~~

~~A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360 in the CHAP rate period.~~

~~B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $527,528 in the CHAP rate period.~~

~~3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive $276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.~~

~~4) Hospitals qualifying under this subsection (b) that are, as of July 1, 2010, designated as a "magnet hospital" by the American Nurses' Credentialing Center will receive a magnet component of $1,500,000 annually for the period July 1, 2010 through December 31, 2014.~~

a~~e~~) Direct Hospital Adjustment (DHA) Criteria

1) Qualifying Criteria

Hospitals may qualify for the DHA under this subsection (c) under the following categories unless the hospital does not provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on or after July 1, 2006, but did provide comprehensive emergency treatment services as defined in 77 Ill. Adm. Code 250.710(a) on January 1, 2006:

A) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i) were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999 and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii) were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999 and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(a)(1)~~(b)(1)(A)~~, and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

B) Illinois hospitals located outside of HSA 6 that had an MIUR greater than 60 percent on July 1, 1999 and an average length of stay less than ten days. The following hospitals are excluded from qualifying under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

C) Children's hospitals, as defined under Section 148.125(d)(3)~~89 Ill. Adm. Code 149.50(c)(3)~~, on July 1, 1999.

~~D) Illinois teaching hospitals, with more than 40 graduate medical education programs on July 1, 1999, not qualifying in subsection (c)(1)(A), (B), or (C) of this Section.~~

~~E)~~ ~~Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999 and provided more than 15,000 total days.~~

~~F)~~ ~~Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1, 1999 and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.~~

~~G)~~ ~~Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999 that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999 and provided 75 or more Alzheimer days for patients diagnosed as having the disease.~~

~~H)~~ ~~Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.~~

D~~I~~) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (a)~~(c)~~(1)(A) through (a)~~(c)~~(1)(C)~~(H) of this Section~~, all other hospitals that had an MIUR greater than 23 percent on July 1, 1999, had an average length of stay less than four days, provided more than 4,200 total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.

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

2) DHA Rates

A) For hospitals qualifying under subsection (a)~~(c)~~(1)(A)~~ of this Section~~ that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than 1.5 standard deviation above the Statewide mean Combined MIUR, will continue to receive the rate in effect as of December 31, 2013, $105.00 per day for hospitals that do not provide obstetrical care and a rate of $142.00 per day for hospitals that do provide obstetrical care, for dates of service through June 30, 2014. For dates of service on or after July 1, 2014, the rate is $0.00.~~, the DHA rates are as follows:~~

~~i)~~ ~~Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.~~

~~ii)~~ ~~Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive $105.00 per day for hospitals that do not provide obstetrical care and $142.00 per day for hospitals that do provide obstetrical care.~~

~~iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.~~

~~iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.~~

B) Hospitals qualifying under subsection (a)~~(c)~~(1)(A) ~~of this Section~~ with an average length of stay less than 3.9 days will continue to receive the rate in effect as of December 31, 2013, $254.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~will also receive the following rates:~~

~~i) County owned hospitals as defined in Section 148.25 with more than 30,000 total days will have their rate increased by $455.00 per day.~~

~~ii) Hospitals that are not county owned with more than 30,000 total days will have their rate increased by $354.00 per day for dates of service on or after April 1, 2009.~~

~~iii) Hospitals with more than 80,000 total days will have their rate increased by an additional $423.00 per day.~~

~~iv) Hospitals with more than 4,500 obstetrical days will have their rate increased by $101.00 per day.~~

~~v) Hospitals with more than 5,500 obstetrical days will have their rate increased by an additional $194.00 per day.~~

~~vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by $147.00 per day.~~

~~vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by $385.00 per day through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $131.00.~~

~~viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999 will have their rate increased by $360.00 per day for dates of service on or after April 1, 2009.~~

~~ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by $650.00 per day for dates of service on or after April 1, 2009.~~

~~x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by $320.50 per day.~~

~~xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by $185.00 per day for dates of service on or after April 1, 2009.~~

~~xii) Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by $148.00 per day.~~

C) Hospitals receiving payments under subsection (a)(2)(A) that have an average length of stay less than four days will continue to have their rate increased by $650.00 per day for dates of service through

February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by $1,040.00 per day. For dates of service on or after July 1, 2014, the rate is $0.00.~~Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:~~

~~i) Qualifying hospitals will receive a rate of $421.00 per day.~~

~~ii) Qualifying hospitals with more than 1,500 obstetrical days will have their rate increased by $824.00 per day through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $369.00.~~

D) Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate continue to be increased by $148.00 per day for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by $287.00 per day. For dates of service on or after July 1, 2014, the rate is $0.00.~~Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:~~

~~i) Hospitals will receive a rate of $28.00 per day.~~

~~ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by $55.00 per day.~~

~~iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by $573.00 per day. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be increased by an additional $47.00, to $620.00.~~

~~iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by:~~

- ~~For hospitals that have fewer than 4,000 total days, $32.00 per day.~~

- ~~For hospitals that have more than 4,000 total days but fewer than 8,000 total days, $363.00 per day for dates of service through December 1, 2014; for dates of service on or after January 1, 2015, the rate is $246.00 per day.~~

- ~~For hospitals that have more than 8,000 total days, $295.00 per day for dates of service through December 31, 2014; for dates of service on or after January 1, 2015, the rate is $178 per day.~~

~~v)~~ ~~Hospitals with more than 3,200 total admissions will have their rate increased by $328.00 per day.~~

E) Hospitals qualifying under subsection (a)(1)(B)~~(c)(1)(D)~~ ~~of this Section~~ that have more than 1,500 obstetrical days will continue to receive the rate in effect as of December 31, 2013, $224.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~will receive the following rates:~~

~~i)~~ ~~Hospitals will receive a rate of $41.00 per day.~~

~~ii)~~ ~~Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.~~

~~iii)~~ ~~Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $191.00 per day for dates of service on or after April 1, 2009.~~

~~iv)~~ ~~Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional $41.00 per day. For dates of service on or after July 1, 2010 through December 31, 2014, this rate shall be further increased by $54.00 per day, to $95.00 per day.~~

F) Hospitals qualifying under subsection (a)(1)(C)~~(c)(1)(E) of this Section~~ that are not located in Illinois, have an MIUR greater than 45 percent, and greater than 4,000 days, will continue to receive the rate in effect as of December 31, 2013, $117.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~will receive $188.00 per day.~~

G) Hospitals qualifying under subsection (a)(1)(D) will continue to receive the rate in effect as of December 31, 2013, $90.00 per day, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of $55.00 per day.~~

~~H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:~~

~~i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of $69.00 per day.~~

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

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

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

~~K) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate~~

~~share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.~~

3) DHA Payments

A) Payments under this subsection (a)~~(c)~~ will be made at least quarterly~~, beginning with the quarter ending December 31, 1999~~.

B) Payment rates will be multiplied by the total days.

~~C) For the CHAP rate period occurring in State fiscal year 2011, total payments will equal the methodologies described in subsection (c)(2) of this Section.~~

~~d) Rural Critical Hospital Adjustment Payments (RCHAP)~~
~~RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:~~

~~1) the product of $1,367 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or~~

~~2) the product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.~~

~~e) Total CHAP Adjustments~~
~~Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.~~

~~f) Critical Hospital Adjustment Limitations~~
~~Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) of this Section, or a Level II trauma center as~~

~~required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under subsection (a)(2). Payments under this Section are subject to federal approval.~~

b~~g~~) Critical Hospital Adjustment Payment Definitions
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.

2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995 CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996 CHAP rate period; etc.

3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.

4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(i)(4)~~(k)(5)~~, plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(i)(5)~~(k)(6)~~, as of July 1, 1999.

5) "Coordinated Care Participating Hospital" means a hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 ILCS 5/5-30 that is one of the following:

A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.

B) Has not been offered a contract by a care coordination plan that pays not less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital

adjustment payments or any other supplement payment that the Department pays directly.

C) Is not licensed to serve the population mandated to enroll in the care coordination program.

6) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

~~7) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.~~

~~8) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.~~

7~~9~~) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

~~10)~~ ~~"Medicaid trauma admission" means those claims billed as admissions for recipients of medical assistance under Title XIX of the Social Security Act that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.~~

~~11)~~ ~~"Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.~~

~~12)~~ ~~"RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.~~

~~13)~~ ~~"RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.~~

8~~14~~) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

9~~15~~) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

10~~16~~) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.296 Transitional Supplemental~~Tertiary Care Adjustment~~ Payments

Effective for dates of service on or after July 1, 2014, to provide stability to the hospital industry in the midst of replacing a twenty year old reimbursement system that relied heavily on non-claims based static payments, in favor of an updated APR-DRG grouper for inpatient services and an entirely new outpatient reimbursement methodology in the EAPG system, the Department shall create transitional supplemental payments to hospitals. These payments are essential to maintaining access to care for an expanding population of Illinois Medical Assistance recipients for a limited time period to allow the hospital providers time to adjust to the new reimbursement policies, rates and methodologies.

a) Transitional Supplemental Payments shall be made to DRG PPS providers with a simulated payment loss under the new inpatient and outpatient systems combined.

1) The following providers will not qualify for Transitional Supplemental Payments:

A) Freestanding psychiatric, rehabilitation, LTAC providers, university-owned large public hospitals, county-owned large public hospitals, children's specialty hospitals and non-cost reporting hospitals.

B) DRG PPS providers with a simulated payment gain under the new inpatient and outpatient systems combined.

2) Simulated payment loss or gain under the new inpatient and outpatient systems combined shall be based on:

A) SFY 2013 legacy system reported claim payments: Reported payments in Illinois Medicaid FFS inpatient and outpatient paid claims data, including Medicare-Medicaid dual eligible claims and non-Medicare eligible claims, for claims with submittal dates during SFY 2013 and admission dates on or after July 1, 2011, excluding outpatient therapy claims, and claims with invalid/ungroupable inpatient DRGs or outpatient EAPGs.

B) SFY 2013 new system simulated claim payments: Simulated payments under the new inpatient and outpatient systems using SFY 2013 claims data described in subsection (a)(2)(A), including MPA/MHVA payments and excluding DSH payments and inpatient GME payment increases.

C) SFY 2011 legacy system supplemental payments, excluding payments that will continue in current form in SFY 2015.

D) All legacy and new system payment amounts used to determine Transitional Supplemental Payments will be adjusted for SMART Act reductions.

E) Estimated payment gain or loss under the combined new inpatient and outpatient systems shall be determined as follows: (Simulated new system SFY 2013 claim payments) – [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].

F) Estimated payment gain or loss percentage under the combined new inpatient and outpatient systems shall be determined as follows: (Estimated payment gain or loss) / [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].

b) Transitional Supplemental Payments for qualifying providers shall be the sum of the following components:

1) Floor Component: Based on the supplemental payments needed to result in a provider's estimated payment loss of negative three percent, rounded to the nearest thousand dollars, using the following formula:

A) [((Reported legacy system SFY 2013 claims payments) + (SFY 2011 legacy system supplemental payments))* 0.97] – (Simulated new system SFY 2013 claim payments).

B) A provider with an estimated payment loss percentage less than three percent will have a Floor Component equal to $0.00.

2) Balance Component: Based on a percent of the provider's remaining estimated loss after including the Floor Component, rounded to nearest thousand dollars, using the following formula:

A) [((Simulated new system SFY 2013 claims payments) + (Floor Component)) – ((Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments))] * (Balance Adjustment Percentage) * -1.

B) Balance Adjustment Percentage based on provider type as follows:

i) Safety Net hospitals: 70 percent

ii) Critical Access hospitals: 70 percent

iii) Hospital with both Perinatal level III and Trauma level I status: 70 percent

iv) All other qualifying DRG PPS hospitals with an estimated payment loss: 55 percent.

c) Timing

1) The Department shall make Transitional Supplemental Payments for the first two years of the new inpatient and outpatient payments systems effective during SFY 2015 and 2016.

2) Commencing October 2015, the Department shall convene a Technical Advisory Group to determine the need to continue any new supplemental payments to maintain access to care to be effective July 1, 2016. Any new supplemental payments may be based on one or more of the following considerations critical to maintaining access to care for those eligible for Medicaid services:

A) Provider-specific payment increases received from the Medicaid expansion population.

B) Provider-specific Medicaid volume (both total volume and Medicaid utilization rate).

C) Provider-specific new system payments compared to UPL cost.

D) Provider-specific new system payments compared to estimated payments under Medicare, using an aggregate Medicare payment-to-charge ratio.

E) Provider-specific payments under the hospital assessment.

F) Available inpatient and outpatient UPL gap for each provider class.

G) The financial implications of the loss of Transitional Supplemental Payments in excess of $10,000,000 and have an MIUR at least of 1.5 standard deviations above the mean.

H) An analysis of new hospital revenues and losses from all sources.

3) Effective July 1, 2016, the Department shall direct unused funds from legacy Transitional Supplemental Payments to increase either inpatient DRG PPS base rates or EAPG PPS conversion factors, adjust current policy adjustors defined in Section 148.140(f) and 89 Ill. Adm. Code 149.100(f) if needed, and/or create new policy adjustors, which may include but are not limited to, Perinatal level II or II+ facilities and

expensive drugs and devices if needed, based on analysis and recommendations from the Technical Advisory Group defined in subsection (c)(2).~~Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Section 148.25(b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), for inpatient admissions occurring on or after July 1, 2002, in accordance with this Section.~~

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

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

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

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

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

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

~~A)~~ ~~Reimbursed under a per diem rate methodology; and~~

~~B)~~ ~~For Delivery or Newborn Care.~~

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

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

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

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

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

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

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

~~ii) CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;~~

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

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

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

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

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

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

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

~~B) For a hospital located:~~

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

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

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

~~A) Reimbursed under a per diem rate methodology; and~~

~~B) For Delivery or Newborn Care.~~

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

~~A) The product of the hospital's:~~

~~i) number of Qualified Admissions; and~~

~~ii) CMAF; and~~

~~B) The sum of the hospital's:~~

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

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

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

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

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

~~A) Assigned by the Department to a DRG that:~~

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

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

~~B) Not a claim:~~

~~i) reimbursed under a per diem rate methodology;~~

~~ii) for Delivery or Newborn Care; or~~

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

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

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

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

~~C) The constant 1.400.~~

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

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

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

~~A) For Delivery or Newborn Care;~~

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

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

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

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

~~B) For Illinois hospitals with:~~

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

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

~~C) For out of state hospitals with:~~

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

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

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

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

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

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

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

~~B) For Delivery or Newborn Care.~~

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

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

~~B) $4,675.00; and~~

~~C) The quotient of:~~

~~i) the number of Qualifying Residents,~~

~~ii) divided by the number of Qualifying Admissions.~~

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

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

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

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

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

~~B) A constant that:~~

~~i) for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, $3,000.00; or~~

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

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

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

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

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

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

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

~~h) Tertiary Care Adjustment~~

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

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.297 Physician Development Incentive Payments~~Pediatric Outpatient Adjustment Payments~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Effective for dates of service on or after July 1, 2014:

a) A Medicaid Graduate Medical Education (GME) fund in Illinois will support and align with the State's current and projected physician workforce needs and goals including:

1) Increasing the number of primary care providers in Illinois;

2) Increasing the number of primary care providers working in medically underserved areas; and

3) Increasing the number of providers who are trained to practice in a patient-centered medical home setting within an integrated delivery system.

b) The performance criteria for incentive payments of the program will be as follows:

1) Resident Continuity Clinics

A) 50 percent of funds are set aside for GME program resident continuity clinics meeting standards for at least one of the following:

i) Level II or III Patient Centered Medical Homes by the National Center for Quality Assurance.

ii) Primary Care Medical Home Certification by the Joint Commission.

iii) Medical Home Accreditation by the Accreditation Association for Ambulatory Health Care.

B) Each program within a hospital meeting one of these certification or accreditation standards will receive an equal share of these funds.

2) Resident Practice Clinics

A) 25 percent of funds will be set aside for resident practice clinics with significant medically underserved populations.

B) Each program within a hospital meeting these standards will receive an equal share of these funds.

3) Continuity of Care Settings

A) 25 percent of funds set aside for written curricula in population medicine based on practice in continuity of care settings. The curriculum must contain competencies in population medicine. Population medicine curriculum competencies should include: preventive medicines; information technology for managing continuity of care practice panels; managing transitions of care; participating in team-based care and supporting patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas.

B) Each program within a hospital meeting these standards will receive an equal share of these funds.

c) Residency programs and the sponsoring medical centers will collect all information to be submitted for this program to HFS by June 1 each GME rate year. This includes, proof of certification requirements required in subsection (b)(1)(A), internal GME residency program data, and queries of GME program recent graduates.

d) The submitted data from eligible GME programs will be reviewed for meeting program performance standards. The Department may require, for corroborating information and audit, any submission.

e) All GME residency programs meeting performance standards and qualifying to receive program funding will be announced annually. Subsequent to its determination of qualifying programs, the Department will disburse program funds to the hospitals that sponsor qualifying GME residency programs.

f) The Department shall recover, through repayment by or recoupment against other funds payable to the hospital, program funds that have been found to have been disbursed in error.

g) Definitions

1) "GME" means graduate medical education.

2) "GME rate year" means the 12-month period beginning on July 1 of each year, with the first GME rate year to begin on July 1, 2014.

3) "Primary care GME programs" means either Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) Post Graduate accredited residency programs in Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics. Programs that are dual accredited by the ACGME and AOA are only eligible for a single yearly payment.

4) "Significant medically underserved populations" means more than 50% of the individuals served by a qualifying residency practice clinic are enrolled in Medicaid or are uninsured. The denominator used in this calculation shall include all resident continuity clinics in a GME program practice. When more than one site is used for resident continuity of care practice, the designated practice site or sites used to calculate percent medically underserved must contain greater than 75% of all patients seen by residents in continuity practice.

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

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

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

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

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

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

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

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

~~C) $169.00.~~

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

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

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

~~C) $169.00.~~

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

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

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

~~C) $305.00.~~

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

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

~~e) Definitions~~

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

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

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

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

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.298 Pediatric Inpatient Adjustment Payments (Repealed)

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

~~a) To qualify for payments under this subsection (a), a hospital must be a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this subsection shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by $816.00 per day. Payments under this subsection will based on the following methodology:~~

~~1) The calculation under this subsection (a) may not exceed more than 850 days.~~

~~2) For the purposes of calculating payments under this subsection (a), the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.~~

~~b) In addition to the payments described under subsection (a) of this Section, any children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), will receive an additional adjustment equal to the product of the hospital's total paid days, excluding Medicare crossover claims, multiplied by $113.00 per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.~~

~~c) For rate years occurring after State fiscal year 2000, total payments made under subsections (a) and (b) of this Section shall be paid at least quarterly.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.300 Payment

Effective for dates of service on or after July 1, 2014:

a) The Department will adjust rate methodologies used to reimburse hospitals to assure compliance with applicable aggregate and hospital-specific federal payment limitations.

b) Effect of Change of Ownership on Payments. When a hospital's ownership changes, payment for hospital services for each patient, including payment adjustments, will be made to the entity that is the legal owner on the date of discharge. Payment will not be prorated between the buyer and seller.

1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished regardless of when the client's coverage began or ended during a stay, or how long the stay lasted.

2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether some of the information is attributable to a period during which a different party legally owned the hospital.

c) Notwithstanding any other provisions of 89 Ill. Adm. Code 148, 149 or 152, a hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as defined in Section 5-30 of the Illinois Public Aid Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of the Illinois Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital, as defined in Section 148.25(f), no later than August 14, 2012, or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care Program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.310 Review Procedure

Effective for dates of service on or after July 1, 2014:

a) ~~Inpatient~~ Rate Reviews

Hospitals shall be notified of their rates for the rate year and shall have an opportunity to request a review, pursuant to subsection (f), of any rate for errors in calculation made by the Department.

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

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

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

1) Hospitals shall be notified of their qualification for DSH ~~and/~~or MPA payment adjustments and shall have an opportunity to request a review pursuant to subsection (f) of the DSH ~~and/~~or MPA add-on for errors in calculation made by the Department. ~~Such a request must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its~~

~~disproportionate share and/or Medicaid Percentage Adjustment qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

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

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

B) Medicaid Inpatient Utilization Rates.

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

ii) Hospitals' Medicaid inpatient utilization rates, as defined in Section 148.120(i)(4)~~148.120(k)(4)~~, which have been derived from unaudited cost reports~~ or HDSC forms~~, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section 148.120(c)(1)(B)~~ and (c)(1)(C)(i) and (ii)~~, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH ~~and/~~or MPA determination.

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

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

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

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

c) Outlier Adjustment Reviews
The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105~~ or Section 148.130, whichever is applicable~~. Hospitals shall be notified of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review, pursuant to subsection (f), of ~~such~~ specific information for errors in calculation made by the Department.~~ Such a request must be submitted in writing to the Department and must be received or~~

~~post marked within 30 days after the date of the Department's notice to the hospital of the specific information that shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

d) Cost Report Reviews

Cost report reviews are described in Section 148.210(a).~~1)Cost reports are required from:~~

~~A) All enrolled hospitals within the State of Illinois;~~

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

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

~~2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days after the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be~~

~~accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~e)~~ ~~Trauma Center Adjustment Reviews~~

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

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

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

e~~f~~) Medicaid High Volume Adjustment Reviews
The Department shall make Medicaid high volume adjustments in accordance with Section 148.112~~148.290(d)~~. Hospitals shall be notified of the Department's determination and have an opportunity to request a review, pursuant to subsection (f). That review~~Review~~ shall be limited to verification that the Medicaid inpatient days were calculated in accordance with Section 148.120. ~~The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital~~

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

f) Rate Review Requirements

1) Requests for Review

A) All requests for review must be submitted in writing and must either be received by the Department, or post marked within 30 days after the date of the Department's notice to the hospital. The request shall include:

i) a clear explanation of any suspected error;

ii) any additional documentation to be considered; and

iii) the desired corrective action.

B) The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

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

3) For purposes of this subsection (f), the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.

~~g) Sole Community Hospital Designation Reviews~~
~~The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if the hospital believes that a technical error has been made in the~~

~~determination. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

~~h) Geographic Designation Reviews~~

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

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

~~i) Critical Hospital Adjustment Payment (CHAP) Reviews~~

~~1) The Department shall make CHAP in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be~~

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

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

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

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

~~C)~~ ~~Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.~~

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

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

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

~~k) Pediatric Outpatient Adjustment Payment Reviews. The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section 148.297. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.297 if the hospital believes that a technical error~~

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

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

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

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

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

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

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

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

~~3)~~ ~~The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments~~

~~and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rural Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

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

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

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

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

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

~~t)~~ ~~Outpatient Service Adjustment Payment Reviews. The Department shall make Outpatient Service Adjustment Payments in accordance with Section 148.103.~~

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

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

~~v)~~ ~~High Volume Adjustment Payment Reviews. The Department shall make High Volume Adjustment Payments in accordance with Section 148.112. Hospitals shall be notified in writing of the results of the High Volume Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the High Volume Adjustment Payments calculation or their ineligibility for High Volume Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days~~

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

~~w)~~ ~~Medicaid Eligibility Payment Reviews. The Department shall make Medicaid Eligibility Payments in accordance with Section 148.402. Hospitals shall be notified in writing of the results of the Medicaid Eligibility Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid Eligibility Payments calculation or their ineligibility for Medicaid Eligibility Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid Eligibility Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid Eligibility Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~x)~~ ~~Medicaid High Volume Adjustment Payment Reviews. The Department shall make Medicaid High Volume Payments in accordance with Section 148.404. Hospitals shall be notified in writing of the results of the Medicaid High Volume Payments determination and calculation. Hospitals shall have a right to appeal the Medicaid High Volume Payments calculation or their ineligibility for Medicaid High Volume Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid High Volume Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Medicaid High Volume Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~y)~~ ~~Intensive Care Adjustment Payment Reviews. The Department shall make Intensive Care Payments in accordance with Section 148.406. Hospitals shall be notified in writing of the results of the Intensive Care Payments determination and calculation. Hospitals shall have a right to appeal the Intensive Care Payments calculation or their ineligibility for Intensive Care Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Intensive Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Intensive Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~z)~~ ~~Trauma Center Adjustment Payment Reviews. The Department shall make Trauma Center Adjustment Payments in accordance with Section 148.408. Hospitals shall be notified in writing of the results of the Trauma Center Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Trauma Center Adjustment Payments calculation or their ineligibility for Trauma Center Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Trauma Center Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Trauma Center Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~aa)~~ ~~Psychiatric Rate Adjustment Payment Reviews. The Department shall make Psychiatric Rate Adjustment Payments in accordance with Section 148.410. Hospitals shall be notified in writing of the results of the Psychiatric Rate Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Psychiatric Rate Adjustment Payments calculation or their ineligibility for Psychiatric Rate Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal~~

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

~~bb)~~ ~~Rehabilitation Adjustment Payment Reviews. The Department shall make Rehabilitation Adjustment Payments in accordance with Section 148.412. Hospitals shall be notified in writing of the results of the Rehabilitation Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Adjustment Payments calculation or their ineligibility for Rehabilitation Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~cc)~~ ~~Supplemental Tertiary Care Adjustment Payment Reviews. The Department shall make Supplemental Tertiary Care Adjustment Payments in accordance with Section 148.414. Hospitals shall be notified in writing of the results of the Supplemental Tertiary Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Tertiary Care Adjustment Payments calculation or their ineligibility for Supplemental Tertiary Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The~~

~~Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~dd)~~ ~~Crossover Percentage Adjustment Payment Reviews. The Department shall make Crossover Percentage Adjustment Payments in accordance with Section 148.416. Hospitals shall be notified in writing of the results of the Crossover Percentage Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Crossover Percentage Adjustment Payments calculation or their ineligibility for Crossover Percentage Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Crossover Percentage Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Crossover Percentage Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~ee)~~ ~~Long Term Acute Care Hospital Adjustment Payment Reviews. The Department shall make Long Term Acute Care Hospital Adjustment Payments in accordance with Section 148.418. Hospitals shall be notified in writing of the results of the Long Term Acute Care Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Long Term Acute Care Hospital Adjustment Payments calculation or their ineligibility for Long Term Acute Care Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Long Term Acute Care Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Long Term Acute Care Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~ff)~~ ~~Obstetrical Care Adjustment Payment Reviews. The Department shall make Obstetrical Care Adjustment Payments in accordance with Section 148.420. Hospitals shall be notified in writing of the results of the Obstetrical Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Obstetrical Care Adjustment Payments calculation or their ineligibility for Obstetrical Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Obstetrical Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Obstetrical Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~gg)~~ ~~Outpatient Access Payment Reviews. The Department shall make Outpatient Access Payments in accordance with Section 148.422. Hospitals shall be notified in writing of the results of the Outpatient Access Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Access Payments calculation or their ineligibility for Outpatient Access Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Access Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Access Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~hh)~~ ~~Outpatient Utilization Payment Reviews. The Department shall make Outpatient Utilization Payments in accordance with Section 148.424. Hospitals shall be notified in writing of the results of the Outpatient Utilization Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Utilization Payments calculation or their ineligibility for Outpatient Utilization Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date~~

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

~~ii) Outpatient Complexity of Care Adjustment Payment Reviews. The Department shall make Outpatient Complexity of Care Adjustment Payments in accordance with Section 148.426. Hospitals shall be notified in writing of the results of the Outpatient Complexity of Care Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Complexity of Care Adjustment Payments calculation or their ineligibility for Outpatient Complexity of Care Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Complexity of Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Complexity of Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~jj) Rehabilitation Hospital Adjustment Payment Reviews. The Department shall make Rehabilitation Hospital Adjustment Payments in accordance with Section 148.428. Hospitals shall be notified in writing of the results of the Rehabilitation Hospital Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Rehabilitation Hospital Adjustment Payments calculation or their ineligibility for Rehabilitation Hospital Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rehabilitation Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Rehabilitation Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and~~

~~documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~kk)~~ ~~Perinatal Outpatient Adjustment Payment Reviews. The Department shall make Perinatal Outpatient Adjustment Payments in accordance with Section 148.430. Hospitals shall be notified in writing of the results of the Perinatal Outpatient Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Perinatal Outpatient Adjustment Payments calculation or their ineligibility for Perinatal Outpatient Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Perinatal Outpatient Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Perinatal Outpatient Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~ll)~~ ~~Supplemental Psychiatric Adjustment Payment Reviews. The Department shall make Supplemental Psychiatric Adjustment Payments in accordance with Section 148.432. Hospitals shall be notified in writing of the results of the Supplemental Psychiatric Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Supplemental Psychiatric Adjustment Payments calculation or their ineligibility for Supplemental Psychiatric Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Supplemental Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Supplemental Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~mm) Outpatient Community Access Adjustment Payment Reviews. The Department shall make Outpatient Community Access Adjustment Payments in accordance with Section 148.434. Hospitals shall be notified in writing of the results of the Outpatient Community Access Adjustment Payments determination and calculation. Hospitals shall have a right to appeal the Outpatient Community Access Adjustment Payments calculation or their ineligibility for Outpatient Community Access Adjustment Payments if the hospital believes that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Outpatient Community Access Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Outpatient Community Access Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

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

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

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.320 Alternatives (Repealed)

~~a) The provisions of Sections 148.250 through 148.310 of this Part shall be in effect during the fiscal year for so long as the Director of the Department finds that:~~

~~1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this Part is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this~~

~~determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within the geographic area.~~

~~2)~~ ~~The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.~~

~~3)~~ ~~The Department has not been enjoined, restrained of otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.~~

~~b)~~ ~~If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during a fiscal year will be approximately the same as would have been made under this Part.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.330 Exemptions

Effective for dates of service on or after July 1, 2014, nothing~~Nothing~~ in this Part~~these rules~~ is intended to prevent a hospital from individually negotiating with the Department to set up an alternate methodology for reimbursement that results in an expenditure that~~which~~ does not exceed the expenditure that~~which~~ would otherwise be made under this Part~~rule~~.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.370 Payment for Sub-acute Alcoholism and Substance Abuse Treatment Services

Effective for dates of service on or after July 1, 2014:

a) The amount approved for payment for sub-acute alcoholism and substance abuse treatment is based on the type and amount of services required by and actually delivered to a recipient. The amount is determined in accordance with prospective rates developed by the Department of Human Services and approved and adopted by the Department ~~of Public Aid~~ (see 77 Ill. Adm. Code 2090.70). The adopted rate shall not exceed the charges to the general public.

b) Rates are generated through the application of formal methodologies specific to each category in accordance with the specifications in 77 Ill. Adm. Code 2090.35, 2090.40 and 2090.70. Rate appeals are allowable pursuant to the specifications in 77 Ill. Adm. Code 2090.80.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.390 Hearings

Effective for dates of service on or after July 1, 2014:

a) The Department may initiate administrative proceedings pursuant to 89 Ill. Adm. Code ~~Part~~ 104.~~,~~ Subpart C to suspend or terminate certification and eligibility to participate in the Illinois Medical Assistance Program where the provider:

1) Has failed to comply with 77 Ill. Adm. Code 2090.40; ~~and/or~~

2) Does not have a valid license for an enrolled treatment service category;

3) Any of the grounds for payment recovery or termination set forth in 89 Ill. Adm. Code 140.15 or 140.16 or 89 Ill. Adm. Code 104.Subpart C are present.

b) When a proceeding is initiated against providers of alcoholism or substance abuse services, the Department shall notify the provider of the intended actions~~action(s)~~. Notice, service and proof of service shall be in accordance with the "Rules of Practice For Medical Vendor Administrative Proceedings" (89 Ill. Adm. Code 104.~~:~~ Subpart C).

c) All hearings held pursuant to these rules shall be conducted by an attorney designated by the Director of the Department as a hearing officer and said hearing shall be conducted under and governed by the applicable "Rules of Practice For Medical Vendor Administrative Proceedings" promulgated by the Department (89 Ill. Adm. Code 104.~~,~~ Subpart C).

d) The hearing officer shall prepare a written report of the case which shall contain findings of fact and recommended decisions with regard to the issues of recoupment, certification and continued participation in the Medicaid Program.

The ~~Associate~~ Director of the Division~~Office~~ of Alcoholism and Substance Abuse (Department of Human Services) may~~shall~~ also make a recommendation ~~that final shall be~~ in writing and forward~~forwarded~~ to the Director of the Department~~of IDPA~~. The Director of the Department shall then make a final decision based on the findings of fact and all recommendations. A final administrative decision shall be issued in writing and contain findings of fact and the final determinations concerning recoupment, certification and continued participation in the Medicaid Program. A copy of the decision shall be served on each party.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.400 Special Hospital Reporting Requirements

Corrective Action Plans. Effective for dates of service on or after July 1, 2014, hospitals~~Hospitals~~ are responsible for assuring that services provided to Medical Assistance Program~~Medicaid program~~ participants meet or exceed the appropriate standards for care. Any provider that is under any corrective action plans~~plan(s)~~, while enrolled with the Department, by any licensing, certification and/or accreditation authority, including, but not limited to, the Illinois Department of Public Health, the federal~~Federal~~ Department of Health and Human Services, a peer review organization, or TJC~~and/or the Joint Commission for Accreditation of Health Care Organization~~, must report the request for the~~such~~ corrective action plans to the Department. Information submitted will remain confidential.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.440 High Volume Adjustment Payments

a) Qualifying criteria. With the exception of a large public hospital, a High Volume Adjustment payment shall be made to each general acute care hospital that provided and was paid for more than 20,500 Medicaid inpatient days.

b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and:

1) $350, for a hospital with a case mix index greater than or equal to the 85th percentile for all qualifying hospitals.

2) $100, for any other hospital.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.442 Inpatient Services Adjustment Payments

a) Qualifying criteria. With the exception of a large public hospital, all Illinois hospitals qualify for the Inpatient Services Adjustment payment.

b) Payment. A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:

1) A general acute care hospital shall receive an annual amount that is equal to 40% of its base inpatient payments.

2) A freestanding specialty hospital shall receive an annual amount that is equal to 60% of its base inpatient payments.

3) A children's hospital shall receive an annual amount that is equal to 20% of its base inpatient payments.

4) A children's hospital shall receive an annual amount that is equal to 20% of its payments for inpatient psychiatric services provided during State fiscal year 2005.

5) An Illinois hospital licensed by the Illinois Department of Public Health (IDPH) as a psychiatric or rehabilitation hospital shall receive an annual amount that is equal to the product of the following factors:

A) Medicaid inpatient days.

B) $1,000.

C) The positive percentage of change in the hospital's MIUR between 2005 and 2007.

6) A children's hospital shall receive an annual amount that is the product of the annual payment as defined in ~~described in~~ Section 148.298 on December 31, 2013, as seen in http://www2.illinois.gov/hfs/Public

Involvement/hospitalratereform/Pages/Rules.aspx, multiplied by:

A) 2.50, for a hospital that is a freestanding children's hospital

B) 1.00, for any other hospital.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.444 Capital Needs Payments

a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital with a 2007 MIUR of 10% or greater qualifies for the Capital Needs payment.

b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and:

1) The difference between the hospital's capital cost per diem and 75th percentile for all hospitals, for hospitals with a 2007 MIUR of 0.3694 or greater with a capital cost per diem that is less than the 75th percentile for all hospitals.

2) The difference between the hospital's capital cost per diem and 60th percentile for all hospital, for any other hospital.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.446 Obstetrical Care Payments

a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital qualifies for the Obstetrical Care payment if the hospital is one of the following:

1) A rural hospital, ~~as~~ defined as being located outside a metropolitan statistical area or located 15 miles or less from a county that is outside a

metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by DPH and must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993)~~in Section 148.25(g)(3)~~, with a Medicaid obstetrical rate greater than 15%.

2) Classified, on December 31, 2006, as a perinatal level III hospital by IDPH and that had a case mix index equal to or greater than the 45th percentile of such perinatal level III hospitals.

3) Classified, on December 31, 2006, as a perinatal level II or II+ hospital by IDPH and that had a case mix index equal to or greater than the 35th percentile, of such perinatal level II and II+ hospitals combined.

b) Payment. Qualifying hospitals shall receive an annual payment that is the product of the hospital's Medicaid obstetrical days and:

1) $1,500, for a hospital qualifying under subsection (a)(1)~~ of this Section~~.

2) $1,350, for a hospital qualifying under subsection (a)(2)~~ of this Section~~.

3) $900, for a hospital qualifying under subsection (a)(3)~~ of this Section~~.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.448 Trauma Care Payments

a) Qualifying criteria. With the exception of a large public hospital, a hospital qualifies for this payment if the hospital is one of the following:

1) A general acute care hospital that, as of July 1, 2007, was designated by DPH~~IDPH~~ as a trauma center.

2) A children's hospital, located in a contiguous state, that has been designated a trauma hospital by that State providing more than 8,000 Illinois Medicaid days.

b) Payment. A hospital shall receive an annual payment that is the sum of the following amounts for which it qualifies:

1) The product of the hospital's Medicaid inpatient general acute care days and $400, for a general acute care hospital designated as a Level II trauma center as identified in Section~~89 Ill. Adm. Code~~ 148.295(a)(3) and (a)(4) as of December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx.

2) The product of the amount of the State fiscal year 2005 Medicaid capital payments and the factor of 3.75, for a general acute care hospital designated as a trauma center as defined~~identified~~ in Section~~89 Ill. Adm. Code~~ 148.295(a) on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx.

3) The product of the hospital's Medicaid general acute care inpatient days and $235, for a hospital that qualifies under (a)(2). ~~of this Section~~

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.450 Supplemental Tertiary Care Payments

a) Qualifying criteria. An Illinois hospital that qualified in SFY~~State fiscal~~ year 2007 for a payment described in Section 148.296, as in effect on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx.

b) Payment. A hospital shall receive an annual payment that is equal to the amount for which it qualified in SFY~~State fiscal year~~ 2007 in Section 148.296, as was in effect on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.452 Crossover Care Payments

a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital that had a ratio of crossover days to total medical assistance inpatient days (utilizing information from 2005 Illinois medical assistance paid claims) greater than 50% and the hospital's case mix index is equal to or greater than the 65th percentile of all case mix indices.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of $1,125 and the inpatient days provided to individuals eligible for Medicaid, as recorded in the Department's paid claims data.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.454 Magnet Hospital Payments

a) Qualifying criteria. With the exception of a large public hospital, a general acute care hospital or a freestanding children's hospital qualifies for Magnet Hospital payment if it meets both of the following criteria:

1) Was, as of February 1, 2008, designated as a "magnet hospital" by the American Nurses' Credentialing Center.

2) A case mix index that is equal to or greater than the 75th percentile for all hospitals.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days, eligibility growth factor, and:

1) $450, for a hospital that has a case mix index equal to or greater than the 75th percentile of all hospitals and an eligibility growth factor that is greater than the mean eligibility growth factor for counties in which the hospital is located.

2) $225, for a hospital that has an eligibility growth factor that is less than or equal to the mean eligibility growth factor for counties in which the hospital is located.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.456 Ambulatory Procedure Listing Increase Payments

a) Qualifying criteria. With the exception of a large public hospital, as defined in Section 148.458(a) Ambulatory Procedure Listing Increase payment shall be shall be made to each Illinois hospital.

b) Payment. Qualifying hospitals shall receive an annual payment that is the sum of:

1) For a hospital that is licensed by the Department of Public Health as a psychiatric specialty hospital, the product of:

A) The hospital's payments for type B psychiatric clinic services provided during SFY~~State fiscal year~~ 2005 that reimbursed through methodologies defined~~described~~ in Section~~subsection~~ 148.140(b)(1)(e) on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx; and~~,~~

B) 3.25.

2) For all other hospitals:

A) The hospital's payments for services provided during SFY~~State fiscal year~~ 2005 that reimbursed through methodologies defined~~described~~ in Section~~Sections~~ 148.140(b)(1)(A) through ~~148.140~~(b)(1)(D) on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx; and~~,~~

B) 2.20.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.458 General Provisions

Unless otherwise indicated, the following apply to Sections 148.440 through 148.456.

a) Definitions

"Base inpatient payments" means, for a given hospital, the sum of payments made using the rates~~ defined in Section 148(b)(1)~~ for services provided during SFY~~State fiscal year~~ 2005 and adjudicated by the Department through March 23, 2007.

"Capital cost per diem" means, for a given hospital, the quotient of:

~~(i)~~ the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by

~~(ii)~~ the total inpatient days from the same cost report to calculate a capital cost per day.

The resulting capital cost per day is inflated to the midpoint of SFY~~State fiscal year~~ 2009 utilizing the national hospital market price proxies hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department shall use the data reported on the hospital's 2005 Medicaid cost report.

"Case mix index" means, for a given hospital, the quotient resulting from dividing:

~~(i)~~ the sum of the all diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for SFY~~State fiscal year~~ 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section~~89 Ill. Adm. Code~~ 148.82, by

~~(ii)~~ the total number of category of service 20 admissions for SFY~~State fiscal year~~ 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Section~~89 Ill. Adm. Code~~ 148.82.

"Children's hospital" means a hospital as described in 89 Ill. Adm. Code~~Section~~ 149.50(c)(3).

"Eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from SFY~~State fiscal year~~ 1998 to SFY~~State fiscal year~~ 2005.

"Freestanding children's hospital" means an Illinois Children's hospital that is licensed by the Illinois Department of Public Health as a pediatric hospital.

"Freestanding specialty hospital" means an Illinois hospital that is neither a general acute care hospital nor a large public hospital nor a freestanding children's hospital.

"General acute care hospital" means an Illinois hospital that operates under a general license (i.e., is not licensed by the Illinois Department of Public Health as a psychiatric, pediatric, rehabilitation, or tuberculosis specialty hospital) and is not a long term stay hospital, as described in Section 148.25(d)(4)~~149.50(c)(4)~~.

"Large public hospital" means a county-owned hospital, as described in Section 148.25(a)~~(b)(1)(A)~~, a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(a)~~(b)(1)(B)~~, or a hospital owned or operated by a State agency, as described in Section 148.25(a)~~(b)(6)~~.

"Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during SFY~~State fiscal year~~ 2005 as adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for

Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during SFY~~State fiscal year~~ 2005, adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical rate" means, for a given hospital, a fraction, the numerator of which is the hospital's Medicaid obstetrical days and the denominator is the hospital's Medicaid inpatient days.

"Medicare crossover rate" means, for a given hospital, a fraction, the numerator of which is the number patient days provided to individuals eligible for both Medicare under Title XVIII and Medicaid under Title XIX of the federal Social Security Act and the denominator of which is the number patient days provided to individuals eligible for medical programs administered by the Department, both as recorded in the Department's paid claims data.

"MIUR" means Medicaid inpatient utilization rate as defined in Section 148.120(i)(4)~~148.120(K)(4)~~.

b) Payment

1) The annual amount of each payment for which a hospital qualifies shall be made in 12 equal installments on or before the seventh State business day of each month. If a hospital closes or ceases to do business, payments will be prorated based on the number of days the hospital was open during the State fiscal year in which the hospital closed or ceased to do business.

2) Monthly payments may be combined into a single payment to a qualifying hospital. Such a payment will represent the total monthly payment a qualifying hospital receives pursuant to Sections 148.440 through 148.456.

3) The Department may adjust payments made pursuant to Article V-A of the Public Aid Code to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

4) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under Article V-A of the Illinois Public Aid Code is exceeded, then the payments under

Article V-A of the Illinois Public Aid Code that exceed the applicable federal upper limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

c) Rate Reviews

1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.440 through 148.456.

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

d) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.460 Catastrophic Relief Payments (Repealed)

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

~~b) Payments~~

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

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

~~B) $8,000,000.~~

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

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

~~B) $175,000.~~

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

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

~~B) $1,600,000 for Illinois hospitals with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~

~~C) $750,000 for Illinois hospitals with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~

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

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

~~B) $1,200,000 for an Illinois hospital with 20 to 50 Title XXI admissions in the Catastrophic Relief Payments base period.~~

~~C) $562,500 for an Illinois hospital with up to 20 Title XXI admissions in the Catastrophic Relief Payments base period.~~

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

~~c) Definitions~~

~~1) "MIUR", for a given hospital, has the meaning ascribed in Section 148.120(i)(4) and shall be determined in accordance with Section 148.120(c) and (f). For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.~~

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

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

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

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

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

~~7) "Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP (Section 148.295) rate~~

~~period and contained within the Department's paid claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.462 Hospital Medicaid Stimulus Payments (Repealed)

~~One-time payments shall be made to all eligible Illinois hospitals, for inpatient and outpatient Medicaid services occurring on or after December 10, 2009, in accordance with this Section. The total payment shall be the sum of the following payment methodologies:~~

~~a) Rural Emergency Services Stimulus Adjustment (RESA)~~

~~1) Qualifying Criteria~~

~~A) Rural Illinois hospitals, as defined at 89 Ill. Adm. Code 148.25(g)(3), licensed by the Department of Public Health (IDPH) under the Hospital Licensing Act, certified by IDPH to participate in the Illinois Medicaid Program, and enrolled with the Department of Healthcare and Family Services to participate in the Illinois Medicaid Program; and~~

~~B) Provide services as required under 77 Ill. Adm. Code 250.710 in an emergency room subject to the requirements under either 77 Ill. Adm. Code 250.2440(k) or 77 Ill. Adm. Code 250.2630(k).~~

~~2) Payment. Hospitals meeting the qualifying criteria shall receive a supplemental outpatient payment equal to the hospital's outpatient ambulatory procedure listing payments for Group 3 services, as defined in Section 148.140(b)(1)(C), except that a qualifying hospital designated as a critical access hospital by IDPH in accordance with 42 CFR 485, subpart F (2001) as of July 1, 2009 shall have the payment determined under subsection (a)(2)(A) of this Section multiplied by 3.5, rounded to the nearest whole dollar.~~

~~b) Obstetrical Care Severity and Volume Stimulus Adjustment (OCSVSA)~~

~~1) Qualifying Criteria~~

~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Perinatal Level III facility in accordance with 77 Ill. Adm. Code 250.1820(f)(1)(C) and that provided more than 2,000 Medicaid obstetrical days.~~

~~2)~~ ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A)~~ ~~The hospital's Medicaid obstetrical days; and~~

~~B)~~ ~~$175.00.~~

~~c)~~ ~~Illinois Trauma Center Stimulus Adjustment (ITCA)~~

~~1)~~ ~~Qualifying Criteria~~
~~With the exception of a large public hospital, a hospital designated as of July 1, 2009 by IDPH as a Level I Trauma Center in accordance with 77 Ill. Adm. Code 515.2030 or 515.2035. For the purposes of this payment, hospitals located in the same city that alternate their Level I Trauma Center designation in accordance with 89 Ill. Adm. Code 148.295(a)(2)(A) shall each be deemed eligible for the payment under this Section.~~

~~2)~~ ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A)~~ ~~The hospital's Medicaid inpatient days; and~~

~~B)~~ ~~$22.00.~~

~~d)~~ ~~Acute Care Across the Board Stimulus Adjustment (ABSA)~~

~~1)~~ ~~Qualifying Criteria~~
~~An Illinois hospital, with the exception of a large public hospital and a hospital identified in 89 Ill. Adm. Code 149.50(c)(4).~~

~~2)~~ ~~Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A)~~ ~~The hospital's Medicaid inpatient days; and~~

~~B) $37.00.~~

~~e) High Volume Medicaid Dependent Provider Stimulus Adjustment (HVMDA)~~

~~1) Qualifying Criteria~~
~~With the exception of a large public hospital and hospitals identified in 89 Ill. Adm. Code 149.50(c)(1), (c)(2) and (c)(4), an Illinois hospital qualifying for designation under 89 Ill. Adm. Code 148.120 or 148.122 for the rate year beginning October 1, 2009 and ending September 30, 2010.~~

~~2) Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~A) The hospital's Medicaid inpatient days; and~~

~~B) $35.00.~~

~~f) Adjustments and Limitations~~

~~1) The provisions of this Section shall be in effect:~~

~~A) Upon approval by the Department of Health and Human Services in the Title XIX State Plan; and~~

~~B) As soon as practicable after the effective date of P.A. 96-821; and~~

~~C) As long as the payments under Sections 148.440 through 148.456 remain eligible for federal match under an approved State Plan Amendment, but not beyond December 31, 2010.~~

~~2) No hospital shall be eligible for payment under this Section that:~~

~~A) Ceases operations prior to federal approval of, and adoption of, administrative rules necessary to effect payments under this Section; or~~

~~B) Has filed for bankruptcy or is operating under bankruptcy protection under any chapter of USC 11 (Bankruptcy Code); or~~

~~C) Discontinues providing a service recognized by one of the payments for which it qualifies; or~~

~~D) Surrenders a license or designation recognized by one of the payments, or has a designation or certification revoked by the authorizing agency or entity.~~

~~3) The Department may pay a portion of payments made under this Section in a subsequent State fiscal year to comply with federal law or regulations regarding hospital-specific payment limitations.~~

~~g) Definitions. Unless otherwise indicated, the following definitions apply to the terms used in this Section.~~

~~"Hospital" means any facility located in Illinois that is required to submit cost reports as mandated in Section 148.210.~~

~~"Large public hospital" means a county-owned hospital, as described in Section 148.25(b)(1)(A), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), or a hospital owned or operated by a State agency, as described in Section 148.25(b)(6).~~

~~"Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005 as adjudicated by the Department through March 23, 2007.~~

~~"Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover day), for admissions occurring during State fiscal year 2005, as adjudicated by the Department through March 23, 2007.~~

~~"Outpatient Ambulatory Procedure Listing Payments" means, for a given hospital, the sum of payments for individuals covered under the Title XIX Medicaid State Plan, for its ambulatory procedure listing Group 3 services as described in Section 148.140(b)(1)(C), excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through March 23, 2007.~~

~~h)~~ ~~Rate Reviews~~
~~Rate reviews shall be conducted in accordance with 89 Ill. Adm. Code 148.458(c)(2).~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 148.464 General Provisions

Unless otherwise indicated, the following apply to Sections 148.466 through 148.486.

a) For any children's hospital that did not charge for its services during the base period, the Department shall use data supplied by the hospital to determine payments using similar methodologies for freestanding children's hospitals under Sections 148.484 and 148.486.

b) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during SFY~~State fiscal year~~ 2009 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed.

c) Payments

1) For the period beginning June 10, 2012 through June 30, 2012, the annual payment on services will be prorated by multiplying the payment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days.

2) Effective July 1, 2012, payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of these payment methodologies or any waiver required

under 42 CFR 433.68, at which time the sum of amounts required prior to the date of notification is due and payable.

3) Payments are not due and payable until these payment methodologies are approved by the federal Government and the assessment imposed under Section 5A-2(b-5) of the Public Aid Code, as implemented by 89 Ill. Adm. Code 140.80(b)(2), is determined to be a permissible tax under Title XIX of the Social Security Act.

4) Accelerated Schedule. The Department may, when practicable, accelerate the schedule upon which payments authorized under Sections 148.466 through 148.486 are made.

5) The Department may, in accordance with the IAPA, adjust payments under Sections 148.466 through 148.486 to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

6) If the federal Centers for Medicare and Medicaid Services find that any federal Upper Payment Limit applicable to the payments under Sections 148.466 through 148.486 is exceeded, then the payments under Sections 148.466 through 148.486 that exceed the applicable federal Upper Payment Limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

d) Definitions

Unless the context requires otherwise or unless provided otherwise in Sections 148.466 through 148.486, the terms used in Section 148.484 for qualifying criteria and payment calculations shall have the same meanings as those terms are given in this Part as in effect on October 1, 2011. Other terms shall be defined as indicated in this subsection (d).

"Medicaid Days", "Ambulatory Procedure Listing Services" and "Ambulatory Procedure Listing Payments" do not include any days, charges or services for which Medicare or a Managed Care Organization reimbursed on a capitated basis was liable for payment, except as explicitly stated otherwise in Sections 148.466 through 148.486.

"Ambulatory Procedure Listing Services" means, for a given hospital, ambulatory procedure listing services, as described in Section 148.140(b), as in effect on June 30, 2009, provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in SFY~~State fiscal year~~ 2009 that were adjudicated by the Department through September 2, 2010.

"Case Mix Index" means, for a given hospital, the sum of the per admission (DRG) relative weighting factors in effect on January 1, 2005, for all general acute care admissions for SFY~~State fiscal year~~ 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, as in effect on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, divided by the total number of general acute care admissions for SFY~~State fiscal year~~ 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under Section 148.82, as was in effect on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx.

"Emergency Room Ratio" means, for a given hospital, a fraction, the denominator of which is the number of the hospital's outpatient ambulatory procedure listing and end-stage renal disease treatment services provided for SFY~~State fiscal year~~ 2009 and the numerator of which is the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B and 3C for SFY~~State fiscal year~~ 2009.

"Estimated Medicaid Inpatient Days" means a percentage of actual inpatient Medicaid days to total inpatient days for the period July 1, 2011 to June 30, 2012, applied to total actual inpatient days for SFY~~State fiscal year~~ 2005.

"Estimated Medicaid Outpatient Services" means the percentage of actual outpatient Medicaid services to total outpatient services for the period of July 1, 2011 through June 30, 2012, applied to total actual outpatient services for SFY~~State fiscal~~ year 2005.

"Large Public Hospital" means ~~a county-owned~~ hospital, as described in Section 148.25(a)~~(b)(1)(A), a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), or a hospital owned or operated by a State agency, as described in Section 148.25(b)(6)~~.

"Medicaid Inpatient Day" means, for a given hospital, the sum of days of inpatient hospital days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during SFY~~State fiscal year~~ 2009 that were adjudicated by the Department through June 30, 2010.

"Medicaid General Acute Care Inpatient Day" means, a Medicaid inpatient day, as described in this subsection (d), for general acute care hospitals, and specifically excludes days provided in the hospital's psychiatric or rehabilitation units.

"Outpatient End-Stage Renal Disease Treatment Services" means, for a given hospital, the services, as described in Section 148.140(g)~~(c)~~, provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding payments for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in SFY~~State fiscal year~~ 2009 that were adjudicated by the Department through September 2, 2010.

e) Rate Reviews

1) A hospital shall be notified in writing of the results of the payment determination pursuant to Sections 148.466 through 148.486.

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

f) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.466 Magnet and Perinatal Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital qualifies for a Magnet and Perinatal Hospital Payment if it meets both of the following criteria:

1) Was recognized as a "magnet hospital" by the American Nurses Credentialing Center as of August 25, 2011.

2) Was designated a Level III Perinatal Center as of September 14, 2011.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid general acute care inpatient days and:

1) $470 for hospitals with a case mix index equal to or greater than the 80th percentile of case mix indices for all Illinois hospitals.

2) $170 for all other hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.468 Trauma Level II Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Trauma Level II Payment if it was designated as a Level II trauma center as of July 1, 2011.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid general acute care inpatient days and:

1) $470, for hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for all Illinois hospitals.

2) $170, for all other hospitals.

c) For the purposes of this adjustment, hospitals located in the same city that alternate their trauma center designation as defined in Section 148.295(a)(2) on December 31, 2013, as seen in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, shall have the adjustment provided under this Section divided between the two hospitals.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.470 Dual Eligible Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Dual Eligible Hospital Payment if it meets both of the following criteria:

1) Has a ratio of crossover days to total inpatient days for programs administered by the Department under Title XIX of the Social Security Act (utilizing information from 2009 paid claims) that is greater than 50%.

2) Has a case mix index equal to or greater than the 75th percentile of case mix indices for all Illinois hospitals.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days, including crossover days, and $400.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.472 Medicaid Volume Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the Medicaid Volume Hospital Payment if it meets all of the following criteria:

1) Provided more than 10,000 Medicaid inpatient days of care;

2) Has a Medicaid Inpatient Utilization Rate (MIUR) of at least 29.05%, for the rate year 2011 Disproportionate Share determination; and

3) Is not eligible for Medicaid Percentage Adjustment (MPA) Payments for rate year 2011.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Medicaid inpatient days and $135.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.474 Outpatient Service Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, Outpatient Service Adjustment Payments shall be paid to each Illinois hospital.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of $100 and the hospital's outpatient Ambulatory Procedure Listing services (excluding categories 3B and 3C) and the hospital's outpatient end-stage renal disease treatment services.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.476 Ambulatory Service Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, Ambulatory Service Adjustment Payments shall be paid to each Illinois hospital.

b) Payment. Qualifying hospitals shall receive an annual payment that is:

1) For each Illinois freestanding psychiatric hospital, the product of $200 and the hospital's Ambulatory Procedure Listing services for category 5A.

2) For all other Illinois hospitals, the product of $105 and the hospital's outpatient Ambulatory Procedure Listing services for categories 3A, 3B and 3C.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.478 Specialty Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, Specialty Hospital Payments shall be paid to an Illinois hospital that is one of the following:

1) A Long Term Acute Care Hospital.

2) A hospital devoted exclusively to the treatment of cancer.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of $700 and the hospital's outpatient Ambulatory Procedure Listing services and the hospital's end-stage renal disease treatment services (including services provided to individuals eligible for both Medicaid and Medicare).

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.480 ER Safety Net Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois general acute care hospital shall qualify for the ER Safety Net Payment if it meets all of the following criteria:

1) Has an emergency room ratio equal to or greater than 55%;

2) Was not eligible for Medicaid percentage adjustments payments in rate year 2011;

3) Has a case mix index equal to or greater than the 20th percentile; and

4) Was not designated as a trauma center by the Illinois Department of Public Health on July 1, 2011.

b) Payment. A qualifying hospital shall receive an annual payment that is the product of the hospital's Ambulatory Procedure Listing services and outpatient end-stage renal disease treatment services and:

1) $225 for each hospital with an emergency room ratio equal to or greater than 74%.

2) $65 for all other hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.482 Physician Supplemental Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, physician services eligible for this Physician Supplemental Adjustment Payment are those provided by physicians employed by or who have a contract to provide services to patients of the following hospitals:

1) Illinois general acute care hospitals that:

A) Provided at least 17,000 Medicaid inpatient days of care in State fiscal year 2009; and

B) Was eligible for Medicaid Percentage Adjustment Payments in rate year 2011.

2) Illinois freestanding children's hospitals, as defined in Section 148.25~~89 Ill. Adm. Code 149.50(c)(3)(A)~~.

b) Payment. A qualifying hospital shall receive an annual payment based upon a total pool of $6,960,000. This pool shall be allocated among the eligible hospitals based on the following:

1) The difference between the upper payment limit for what could have been paid under Medicaid for physician services provided during State fiscal year 2009 by physicians employed by, or who had a contract with, the hospital, and the amount that was paid under Medicaid for those services.

2) In no event shall an individual hospital receive an annual, aggregate adjustment amount on physician services in excess of $435,000, except that any amount that is not distributed to a hospital because of the upper payment limit shall be reallocated among the remaining eligible hospitals that are below the upper payment limit on a proportionate basis.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.484 Freestanding Children's Hospital Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois freestanding children's hospital that did not bill for services in 2005 shall qualify for the Freestanding Children's Hospital Adjustment Payments.

b) Payment. A qualifying hospital shall receive an annual amount that is the product of the following:

1) Estimated Medicaid inpatient days; and

2) The quotient of the sum of the amounts calculated for children's hospitals at Section 148.442(b)(3) and (b)(6) and the Medicaid inpatient days for those same hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 148.486 Freestanding Children's Hospital Outpatient Adjustment Payments

a) Qualifying Criteria. With the exception of a large public hospital, an Illinois freestanding children's hospital that did not bill for services in 2005 shall qualify for the Freestanding Children's Hospital Outpatient Payments.

b) Payment. A qualifying hospital shall receive an annual amount that is the product of the following:

1) Estimated Medicaid outpatient services reimbursed through methodologies described in Section 148.140(b)(1)(A) through (D); and

2) The quotient of the sum of the amounts calculated at Section 148.456(b)(2) and services provided during State fiscal year 2005 reimbursed through methodologies described in Section 148.140(b)(1)(A) through (D) for those same hospitals.

c) This Section shall no longer be in effect as of January 1, 2015.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART F: EMERGENCY PSYCHIATRIC DEMONSTRATION PROGRAM

Section 148.860 Community Connect IMD Hospital Payment

Effective for dates of service on or after July 1, 2014:

a) The Community Connect IMD hospital in the demonstration program will be reimbursed on an incentive-driven basis. The Department will reimburse the initial claim for the psychiatric admission at 80% of the psychiatric hospital rate. The remainder of the full 100% of the psychiatric hospital rate will be paid if the individual remains stable in the community with no further psychiatric hospitalization for 45 days after the level of care assessment.

b) Payment for any individual who cannot be discharged because the individual does not have a place to go and appropriate services cannot be implemented, but who is not an inpatient based on medical necessity, will be 50% of the alternate cost per diem rate as defined~~described~~ in Section 148.270 and 89 Ill. Adm. Code 152.200 on July 1, 2012.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 148.TABLE C List of Metropolitan Counties by SMSA Definition

"SMSA" means Standard~~State~~ Metropolitan Statistical Area as defined by the U.S. Office of Management and Budget (OMB)~~Areas~~.

Boone	Champaign	Clinton	Cook	DuPage
Henry	Kane	Kankakee~~Lake~~	Lake~~Macon~~	Macon~~Madison~~
Madison~~McHenry~~	McHenry~~McLean~~	McLean~~Menard~~	Menard~~Monroe~~	Monroe~~Peoria~~
Peoria~~Rock Island~~	Rock Island	Sangamon~~St. Clair~~	St. Clair	Tazewell~~Will~~
	~~Sangamon~~		~~Tazewell~~	
Will~~Winnebago~~	Winnebago	Woodford		
	~~Woodford~~			

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

2) Code Citation: 89 Ill. Adm. Code 149

3)

Section Numbers:	Proposed Action:
149.5	Repeal
149.10	Amend
149.25	Amend
149.50	Amend
149.75	Amend
149.100	Amend
149.105	Amend
149.125	Repeal
149.150	Repeal

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11]

5) Complete Description of the Subjects and Issues Involved: These administrative rules are required pursuant to the SMART Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

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

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

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

9) Does this rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: 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., 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@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].

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 2014

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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

PART 149
DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section
149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (Repealed)
149.10 Applicability of Other Provisions
149.25 General Provisions
149.50 Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System
149.75 Conditions for Payment Under the DRG Prospective Payment System
149.100 ~~Basic~~ Methodology for Determining DRG PPS~~Prospective~~ Payment Rates
149.105 Payment For Outlier Cases
149.125 Special Treatment of Certain Facilities (Repealed)
149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
149.150 Payments to Hospitals Under the DRG Prospective Payment System (Repealed)
149.175 Payments to Contracting Hospitals (Repealed)
149.200 Admitting and Clinical Privileges (Repealed)
149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)
149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
149.250 Contract Monitoring (Repealed)
149.275 Transfer of Recipients (Repealed)
149.300 Validity of Contracts (Repealed)
149.305 Termination of ICARE Contracts (Repealed)
149.325 Hospital Services Procurement Advisory Board (Repealed)

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

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 through 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill.

Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. 10674, effective July 1, 1995; amended at 21 Ill. Reg. 2238, effective February 3, 1997; emergency amendment at 22 Ill. Reg. 13064, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19866, effective October 30, 1998; amended at 25 Ill. Reg. 8775, effective July 1, 2001; amended at 26 Ill. Reg. 13676, effective September 3, 2002; emergency amendment at 27 Ill. Reg. 11080, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18872, effective November 26, 2003; amended at 28 Ill. Reg. 2836, effective February 1, 2004; amended at 38 Ill. Reg. _____, effective _____.

Section 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (Repealed)

~~a) Sections 149.25 through 149.150 describe:~~

~~1) The basis of payment for inpatient hospital services under the DRG PPS and set forth the general basis for the system;~~

~~2) Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;~~

~~3) Conditions that must be met for a hospital to receive payment under the DRG PPS;~~

~~4) The methodology by which DRG prospective rates are determined;~~

~~5) The methodology for determining additional payments for outlier cases;~~

~~6) The rules for special treatment of certain facilities; and~~

~~7) The types, amounts and methods of payment to hospitals under the DRG PPS.~~

~~b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:~~

~~1) Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.~~

~~2) Exceptions. The provisions of subsection (b)(1) above shall not apply to:~~

~~A) Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.~~

~~B) Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or Section 149.100(c)(1)(A), whichever is applicable.~~

~~C) The inpatient payment adjustments described in 89 Ill. Adm. Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.~~

~~c) Definitions~~
~~Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:~~

~~1) "DRG grouper" means:~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and~~

~~populations, as described in Section 149.100(a)(1).~~

~~B)~~ ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).~~

~~2)~~ ~~"Medicare weighting factor" means:~~

~~A)~~ ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~

~~B)~~ ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).~~

~~3)~~ ~~"PPS Pricer" means:~~

~~A)~~ ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.~~

~~B)~~ ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer version that is in effect 90 days prior to the date of admission.~~

~~4)~~ ~~"Marginal Cost Factor":~~

~~A)~~ ~~For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the marginal cost factor shall be the same as that employed by Medicare on September 1, 1992.~~

~~B)~~ ~~For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the marginal cost factor shall be the same as that employed by Medicare 90 days prior to the date of admission.~~

~~5) "Cost Outlier Threshold":~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the cost outlier threshold shall be the same as that employed by Medicare on September 1, 1992, adjusted for the differences in Medicare and Medicaid policies and population, as described in Section 149.100(a)(1).~~

~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the cost outlier threshold/fixed loss threshold shall be the same as that employed by Medicare 90 days prior to the date of admission.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 149.10 Applicability of Other Provisions

Effective for dates of service on or after July 1, 2014, the~~The~~ following provisions, in addition to those provisions specifically cited in this Part, shall apply to hospitals reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS):

a) The general requirements applicable to all hospital services, as described in General Provisions of 89 Ill. Adm. Code 148, Subpart A.~~Participation, as described in 89 Ill. Adm. Code 148.20.~~

b) Organ transplant services, as described in 89 Ill. Adm. Code 148.82~~Definitions and Applicability, as described in 89 Ill. Adm. Code 148.25~~.

~~c) General requirements, as described in 89 Ill. Adm. Code 148.30.~~

~~d) Special requirements, as described in 89 Ill. Adm. Code 148.40.~~

~~e) Covered hospital services, as described in 89 Ill. Adm. Code 148.50.~~

~~f) Services not covered as hospital services, as described in 89 Ill. Adm. Code 148.60.~~

~~g) Limitations on hospital services, as described in 89 Ill. Adm. Code 148.70.~~

c~~h~~) Hospital outpatient and hospital-based clinic services, as described in 89 Ill. Adm. Code 148.140.

d~~i~~) Payment for pre-operative days and~~,~~ patient specific orders, ~~and services which can be performed in an outpatient setting,~~ as described in 89 Ill. Adm. Code 148.180.

e~~j~~) Copayments, as described in 89 Ill. Adm. Code 148.190.

f~~k~~) Filing cost reports, as described in 89 Ill. Adm. Code 148.210.

g~~l~~) Review procedure, as described in 89 Ill. Adm. Code 148.310.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.25 General Provisions

Effective for dates of service on or after July 1, 2014:

a) Basis of Payment

1) Payment on a Per Discharge Basis

A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

B) The DRG prospective payment rate for each discharge (as defined in subsection (b)~~ below~~) is determined according to the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105 and 149.125, as appropriate. The rates paid shall be those in effect on the date of admission.

2) Payment in Full

A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating

costs (as described in subsection (a)(3)~~ below~~) incurred in furnishing services covered under the Medicaid Program.

B) Except as provided for in Section~~subsection~~ 149.100(g),~~(b) below,~~ the full DRG prospective payment amount, as determined under Section~~Sections~~ 149.100~~and 149.150, as appropriate~~, is made for each inpatient stay~~ during which there is at least one Medicaid eligible day of care~~.

~~3) Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:~~

~~A) Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;~~

~~B) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;~~

~~C) Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990);~~

~~D) Malpractice insurance costs related to services furnished to inpatients; and~~

~~E) Hospital-based physician costs as described in Section 149.75(h)(1)(A).~~

~~4) Excluded Costs/Services. The following inpatient hospital costs are excluded from the DRG prospective payment amounts:~~

~~A) Transplantation cost, including acquisition cost incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.82. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~

~~B)~~ ~~Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~

~~C)~~ ~~Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.~~

~~D)~~ ~~Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.~~

~~E)~~ ~~Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).~~

~~F)~~ ~~Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.~~

~~5)~~ ~~Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:~~

~~A)~~ ~~Atypically long or extraordinary costly (outlier) cases, as described in Section 149.105.~~

~~B)~~ ~~Certain costs excluded from the prospective payment rate under subsection (a)(4) above.~~

~~C)~~ ~~The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125(a)(2)).~~

~~D) Specific inpatient payment adjustments (as defined and determined in Section 149.125(a)(3)).~~

~~b) Discharges and Transfers~~

~~1) Discharges. A hospital inpatient is considered discharged when any of the following occurs:~~

~~A) The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).~~

~~B) The patient dies in the hospital.~~

~~2) Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).~~

~~3) Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~

~~4) Payment to a Hospital Transferring an Inpatient to Another Hospital or District Part Unit~~

~~A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.~~

~~B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).~~

~~C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.~~

~~D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.~~

~~c) Admission Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.~~

~~d) DRG Classification System~~

~~1) The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), modified to handle additional DRGs and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.~~

~~2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 149.50 Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System

Effective for dates of service on or after July 1, 2014:

a) Inpatient Services Subject to Submission for DRG Grouping. All hospital inpatient services provided to enrollees of the Medical Assistance programs, without regard to balance due or expected reimbursement methodology to be applied by the Department, must be documented on a claim and submitted to the Department. The Department shall process and group all hospital inpatient claims through the DRG grouper.~~Hospital Services Subject to the DRG Prospective Payment System~~

~~1) Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.~~

~~2) Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:~~

~~A) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d) below.~~

~~B) The services are furnished by a nonparticipating out-of-state hospital (as described in subsection (c)(5) below).~~

~~C) The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6) below) in the transition period of DRG PPS implementation.~~

~~D) The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be exempted from the DRG PPS in accordance with subsection (c)(7) below.~~

~~E) The payment for services is covered by a health maintenance organization (HMO).~~

b) Excluded from DRG PPS reimbursements are:~~and Exempted Hospitals and Hospital Units: General Rules~~

1) Psychiatric services provided by:~~Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in subsection (c) below.~~

A) A psychiatric hospital, as described in 89 Ill. Adm. Code 148.25(d)(1).

B) A distinct part psychiatric unit, as described in 89 Ill. Adm. Code 148.25(c)(1).

2) Physical rehabilitation services provided by:~~Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.250 through 148.300 with the exception of those hospitals described in subsection (c)(8) below. The hospitals described in subsection (c)(8) below are reimbursed in accordance with 89 Ill. Adm. Code 148.160 or 148.170, as appropriate.~~

A) A rehabilitation hospital, as described in 89 Ill. Adm. Code 148.25(d)(2).

B) A distinct part rehabilitation unit, as described in 89 Ill. Adm. Code 148.25(c)(2).

3) Services provided by a long term acute care hospital, as described in 89 Ill. Adm. Code 148.25(d)(4), that are not psychiatric services or services described in subsections (b)(6) through (b)(7).

4) Inpatient services, reimbursed pursuant to 89 Ill. Adm. Code 148.330.

5) Services provided by a large public hospital, as described in 89 Ill. Adm. Code 148.25(a).

6) Hospital residing long term care services, as described in 89 Ill. Adm. Code 148.50(c).

7) Sub-acute alcoholism and substance abuse treatment services, as defined in 77 Ill. Adm. Code 2090.40.

8) Inpatient services provided by Children's Specialty Hospitals as described in 89 Ill. Adm. Code 148.116.

~~e) Excluded Hospitals: Classifications. Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.~~

~~1) Psychiatric Hospitals. A psychiatric hospital must:~~

~~A) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and~~

~~B) Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.~~

~~2) Rehabilitation Hospitals. A rehabilitation hospital must:~~

~~A) Hold a valid license as a physical rehabilitation hospital; and~~

~~B) Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.~~

~~3) Children's Hospitals. To qualify as a children's hospital, the facility must have a Provider Agreement to participate in the Medicaid program and be either:~~

~~A) A hospital devoted exclusively to caring for children; or~~

~~B) A general care hospital which includes a facility devoted exclusively to caring for children that meets one of the following definitions:~~

~~i) A facility that is separately licensed as a hospital by a municipality prior to September 30, 1998. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered; or~~

~~ii) A facility that has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization Rate, as defined at 89 Ill. Adm. Code 148.12(k)(5), greater than 55 percent for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days. Qualified children days means the number of hospital inpatient days for recipients under 18 years of age who are eligible under Medicaid, excluding days for normal newborn, obstetrical, psychiatric, Medicare crossover, and rehabilitation services, as determined from the Department's claims data for days occurring in State fiscal year 2001 that were adjudicated by the Department through June 30, 2002. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered.~~

~~4) Long Term Stay Hospitals. A long term stay hospital must:~~

~~A) Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year for which complete information is available; and~~

~~B) Have a Provider Agreement to participate in the Medicaid Program.~~

~~5) Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements. A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under this Part (the DRG Prospective Payment System), and that does not file an Illinois Medicaid cost report.~~

~~6) Hospitals Reimbursed Under Special Arrangements. Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).~~

~~7) Sole Community Hospitals. Hospitals described in Section 149.125(b), which have elected to be exempted from the DRG PPS, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).~~

~~8) County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act. County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.~~

~~d) Excluded Distinct Part Hospital Units~~

~~1) Distinct Part Psychiatric Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).~~

~~2) Distinct Part Rehabilitation Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

Effective for dates of service on or after July 1, 2014:

a) General Requirements

1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medical Assistance~~Medicaid~~ clients, the Department may, as appropriate:

A) Withhold Medicaid payments~~payment~~ (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.

b) Hospital Utilization Control:~~.~~ Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medical Assistance~~Medicaid~~ as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, 2013~~1999~~). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 148.25(d)(1)~~Section 149.50(c)(1)~~, shall be in accordance with federal

regulations.

c) Medical Review Requirements: Admissions and Quality Review
Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

3) The validity of the hospital's diagnostic and procedural information.

4) The completeness, adequacy and quality of the services furnished in the hospital.

5) Other medical or other practice with respect to program participants or billing for services furnished to program participants.

d) Medical Review Requirements: DRG Validation. The Department, or its agent, may require and perform pre- or-post-payment review of diagnosis and procedure codes to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records. The review may be undertaken by way of a sample of discharges. The review may, at the sole discretion of the Department, take place at the hospital or away from the hospital site.

~~1) Coding attestation. Beginning with admissions on or after March 1, 1997, and ending with admissions on or after July 1, 2001, the Health Information Management Director (Medical Records) or his or her designee(s) within the Health Information Management Department must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal and secondary diagnoses, and major procedures as indicated in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the signature of the Health Information~~

~~Management Director or his or her designee(s) within this Department: "I certify that the ICD-9-CM coding of principal and secondary diagnoses and the major procedures performed are accurate and complete based on the contents of the medical record, to the best of my knowledge." The name of the person signing the attestation must be typed or clearly printed and appear on the same page as the signature.~~

~~2) DRG Validation. The Department, or its designated peer review organization, may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.~~

~~3) Sample Reviews~~

~~A) The Department, or its designated peer review organization, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.~~

~~B) Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.~~

~~4) Revision of Coding~~

~~A) If the diagnostic and procedural information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~

~~B) If the information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.~~

e) Utilization Review Requirements: The Department, or its designated peer review

organization, ~~(see~~ as described in 89 Ill. Adm. Code 148.240(j)~~)~~, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews, as defined at 89 Ill. Adm. Code 148.240.

f) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The ~~applicable~~ payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsection~~subsections~~ (f)(1)(B)~~(i) through (v) of this Section~~.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis are:

i) A physician whose salary is included in the hospital's cost report for direct patient care~~ may not bill separately on a fee-for-service basis~~.

ii) A teaching physician who provides direct patient care, ~~may not bill separately on a fee-for-service basis~~ if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis are:

i) A physician whose salary is not included in the hospital's cost report for direct patient care~~ may bill separately on a fee-for-service basis~~.

ii) A teaching physician who provides direct patient care, ~~may bill separately on a fee-for-service basis~~ if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident, ~~may bill separately on a fee-for-service basis~~ when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and

collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, ~~may bill separately on a fee-for-service basis~~ when, by the terms of his or her contract with the hospital, he or she may charge for professional services and does, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a nonteaching administrative or staff position in a hospital or medical school, but only ~~may bill separately on a fee-for-service basis~~ to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.100 ~~Basic~~ Methodology for Determining DRG PPS~~Prospective~~ Payment Rates

Effective for dates of service on or after July 1, 2014:

a) Inpatient hospital services that are not excluded from the DRG PPS pursuant to Section 149.50(b) shall be reimbursed as determined in this Section.

b) Total DRG PPS Payment. Under the DRG PPS, services to inpatients who are:

1) Discharges shall be paid pursuant to subsection (c).

2) Transfers shall be paid pursuant to subsection (g).

3) The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in 89 Ill. Adm. Code 148.290.

c) DRG PPS Payment for Discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:

1) The greater of:

A) 1.0000; or

B) highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.

2) The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Section 149.105, for which the claim qualifies.

d) The DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

1) The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.

2) The DRG base rate, equal to the sum of:

A) The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare inpatient prospective payment system (IPPS) wage index, statewide standardized amount and graduate medical education (GME) factor.

B) The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the statewide standardized amount and the GME factor.

e) Medicare IPPS Wage Index. Medicare IPPS wage index is determined based on:

1) For Medicare IPPS hospitals, the wage index is based on the Medicare IPPS post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare IPPS hospital post-reclass wage index effective October 1, 2012.

2) For non-Medicare IPPS hospitals and non-cost reporting hospitals, the wage index is based on the Medicare IPPS wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare IPPS wage index for the hospital's Medicare CBSA effective October 1, 2012.

f) Policy Adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.

1) Transplantation Services

A) Policy adjustment factor: 2.11.

B) Qualifying Criteria

i) The hospital meets all requirements to perform transplantation services, including but not limited to those detailed in 89 Ill. Adm. Code 148.82.

ii) The claim has been grouped to one of the following DRGs:

001 Liver transplant.
002 Heart and/or lung transplant.
003 Bone marrow transplant.
006 Pancreas transplant.
440 Kidney transplant.

2) Trauma Services

A) Policy adjustment factor:

i) 2.9100, if the hospital is a level I trauma center.

ii) 2.7600, if the hospital is a level II trauma center.

B) Criteria:

i) Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.

ii) The claim has been grouped to one of the following DRG:

020 Craniotomy for trauma.
055 Head trauma, with coma lasting more than one hour or no coma.
056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.
057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.
135 Major chest and respiratory trauma.
308 Hip and femur procedures for trauma, except joint replacement.
384 Contusion, open wound and other trauma to skin and subcutaneous tissue.
910 Craniotomy for multiple significant trauma.
911 Extensive abdominal/thoracic procedures for multiple significant trauma.
912 Musculoskeletal and other procedures for multiple significant trauma.
930 Multiple significant trauma, without operating room procedure.

3) Perinatal Services

A) Policy adjustment factor:

i) 1.3500, if the DRG to which the claim is grouped has an SOI of 1.

ii) 1.4300, if the DRG to which the claim is grouped has an SOI of 2.

iii) 1.4100, if the DRG to which the claim is grouped has an SOI of 3.

iv) 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

B) Criteria:

i) Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission.

ii) The claim has been grouped to one of the following major diagnostic categories (MDC):

14 Pregnancy, childbirth and puerperium.

15 Newborn and other neonates.

g) DRG PPS Payment for Transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be the lesser of:

1) The amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge; or

2) The product, rounded to the nearest hundredth, of the following:

A) The quotient resulting from dividing the amount that would have been paid pursuant to subsection (c) had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.

B) The length of stay plus the constant 1.0.

h) Updates to DRG PPS Reimbursement. The Department may annually review the components listed in subsection (c) and make adjustments as needed.

i) Definitions

"Allocated static payments" means the adjustment payments made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies outlined in http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Discharge" means a hospital inpatient that:

has been formally released from the hospital, except when the patient is a transfer; or

died in the hospital.

"DRG" means diagnosis related group, as defined in the DRG grouper, based on the principal diagnosis, surgical procedure used, age of patient, etc.

"DRG average length of stay" means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

"DRG grouper" means the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred; except that, for the calendar year beginning January 1, 2014, DRG grouper means version 30 of the APR-DRG software.

"DRG PPS" means the DRG prospective payment system described in this Part.

"DRG weighting factor" means each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper and the Illinois experience adjustment.

"GME factor" means the Graduate Medical Education factor applied to major teaching hospitals determined such that simulated payments under the new inpatient system with GME factor adjustments are $3 million greater than simulated payments under the new inpatient system without GME factor adjustments, using inpatient base period paid claims data.

"Illinois experience adjustment" means:

for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth;

for subsequent calendar years, the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

"Inpatient base period claims data" means: State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

"Inpatient stay" means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

"Length of stay" means the number of days the patient was an inpatient in the hospital, with the day the patient became a discharge or transfer not counting toward the length of stay.

"Medical assistance" means one of the programs administered by the Department that provides health care coverage to Illinois residents.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

"Medicare IPPS labor share percentage" means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater than 1.0 or 0.6200 for all other hospitals.

"Medicare IPPS non-labor share" means the difference of 1.0 and the Medicare IPPS labor share percentage.

"MDC" means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

"SOI" means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic decompensation or organ system loss of function experienced by the patient) and risk of (the likelihood of) dying.

"Statewide standardized amount" means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS payments, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are $355 million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

"Transfer" means a hospital inpatient that has been placed in the care of another hospital, except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

~~a) DRG Classification and Weighting Factors~~

~~1) DRG Classification. The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), to classify inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412), with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.~~

~~2) DRG Weighting Factors~~

~~A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:~~

~~i) Use the Medicare geometric mean length of stay for each diagnostic related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.~~

~~ii) Calculate the Medicaid geometric mean length of stay for each diagnostic related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.~~

~~B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III~~

~~perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.~~

~~i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report divided by the number of discharges for that DRG.~~

~~ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).~~

~~C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.~~

~~D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant; DRG 495, lung transplant.~~

~~E) Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.~~

~~i) For rate periods beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the~~

~~weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(c)(2).~~

~~ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(c)(2).~~

~~3) Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.~~

~~A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.~~

~~B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.~~

~~C) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.~~

~~4) Review of DRG Assignment~~

~~A) A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.~~

~~B) The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.~~

~~C) Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.~~

~~b) Illinois Rates for Admission~~

~~1) Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).~~

~~2) The payments described in 89 Ill. Adm. Code 148.82 shall be effective for services provided on or after July 1, 1992.~~

~~c) Determining Prospective Payment Rates~~

~~1) Federal/Regional Blended Rate Per Discharge~~

~~A) Except as specified in subsection (c)(1)(B) below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, and as computed by the PPS Pricer, as described in Section 149.5(c)(3).~~

~~B) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently~~

~~reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:~~

~~i) Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.~~

~~ii) Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.~~

~~2) Hospital-Specific Portion~~
~~The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers and Medicare dependent hospitals, and rural hospitals deemed urban.~~

~~3) DRG PPS Base Rate~~
~~The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.~~

~~4) Payment Adjustments~~
~~In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments for capital costs in accordance with Section 149.150(c); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code 148.150; various specific inpatient payment adjustments, as applicable, in accordance with 89 Ill. Adm. Code 148.290.~~

~~d) Application of Upper Payment Limits. The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.105 Payment For Outlier Cases

Effective for dates of service on or after July 1, 2014:

a) Outlier adjustment determination. Except as provided in subsection (b), the Department may provide for additional payment, approximating a hospital's marginal cost of covered inpatient hospital services beyond thresholds specified by the Department. To qualify for the payment, the claim must meet the following criteria:~~General Provisions~~

1) The services on the claim must be reimbursable under the DRG PPS.~~Except as provided in subsections (a)(3) and (a)(4) of this Section, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following subsections (A) or (B) apply. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.~~

~~B) For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier~~

~~cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.~~

2) The DRG grouper must be able to assign the claim to a DRG.~~The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3) of this Section, exceed the greater of:~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), $34,000 as adjusted for the hospital's labor market, or the hospital's DRG PPS base rate as described in Section 149.100(c)(1) multiplied by two.~~

~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.~~

3) The estimated claim cost for a claim exceeds the claim outlier threshold for the DRG to which the claim has been assigned.~~The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed:~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section.~~

~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.~~

~~4) The Department will not provide outlier payments for:~~

~~A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.~~

~~B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).~~

~~5) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:~~

~~A) The admission was medically necessary and appropriate.~~

~~B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.~~

~~C) The services were ordered by the physician, actually furnished, and nonduplicatively billed.~~

~~D) The validity of the diagnostic and procedural coding.~~

~~E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.~~

b) Estimated Claim Cost. Estimated claim cost is based on the product of the claim total covered charges and the hospital's Medicare IPPS outlier cost-to-charge ratio. The Medicare IPPS outlier cost-to-charge ratio is determined based on:~~Payment for Extended Length-of-Stay Cases (Day Outliers)~~

1) For Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system hospital-specific operating and capital outlier cost-to-charge ratios effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.~~If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.~~

2) For non-Medicare IPPS hospitals and non-cost reporting hospitals located in an urban Medicare CSBA, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system statewide average operating and capital outlier cost-to-charge ratios for urban hospitals for the state in which the hospital is located, effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred. ~~Except as provided in subsection (d) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under subsection (b)(1) is derived by first taking the marginal cost factor, as defined in 89 Ill. Adm. Code 149.5(c)(4), of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(c)(3), by the mean length-of-stay for that DRG.~~

~~3) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.~~

c) Exclusions. No outlier adjustment shall be paid on claims that are:~~Payments for Extraordinarily High Costs Cases (Cost Outliers)~~

1) Inpatient psychiatric, rehabilitation and long-term acute care services excluded from the DRG PPS pursuant to Section 149.50(b).~~If the hospital charges, as adjusted by the method specified in subsection (c)(3), exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or~~

~~submission is not necessary to initiate this payment.~~

2) Claims for which Medicare is the primary payer. ~~The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.~~

~~3) The cost-to-charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), by the Department for each hospital based on the hospital's base fiscal year. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).~~

~~4) If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.~~

~~5) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.~~

d) Outlier Adjustment Payment. The amount of the additional payment shall be determined as the product, rounded to the nearest hundredth, of:

1) the difference resulting from subtracting the claim outlier threshold from the estimated claim cost; and

2) the applicable SOI adjustment factor, rounded to the nearest hundredth.

~~Payment for Extraordinary High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is, subject to the limitations described in subsection (e) of this Section, the greater of the following:~~

~~1) The payment computed under subsection (b) above.~~

~~2) The payment computed under subsection (c) above.~~

e) Definitions

In addition to terms elsewhere defined in this subchapter, terms relating to outlier adjustments are defined as follows:

"Claim outlier threshold" means the sum of the DRG base payment, as defined in Section 149.100(d) and the fixed loss threshold.

"Fixed loss threshold" means the Medicare fixed loss threshold in effect on October 1 preceding the calendar year during which the inpatient discharge occurred; except, for calendar year 2014, it means the Medicare fixed loss threshold in effect on October 1, 2012.

"MDC" means major diagnostic category.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

SOI adjustment factor" means for SOI 1, 0.8000; for SOI 2, 0.8000; for SOI 3, 0.9500; for SOI 4, 0.9500.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMMS 1450), or one of its electronic transaction equivalents.

~~Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department, excluding payments described in 89 Ill. Adm. Code 148.120, for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 149.125 Special Treatment of Certain Facilities (Repealed)

~~a) General Rules~~

~~1) Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b) below, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.5 through 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).~~

~~2) Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120.~~

~~3) Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in 89 Ill. Adm. Code 148.290.~~

~~b) Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:~~

~~1) Medicare Program Designation~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.~~

~~B) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare program effective 90 days prior to the date of admission.~~

~~2) Primary Service Area Designation~~

~~A) Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.~~

~~B) "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.~~

~~3) The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).~~

~~4) The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCCC) for the most recent four quarters for which information is available.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System (Repealed)

~~a) Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (e). In addition to the payments listed in subsections (b) through (e) of this Section, hospitals shall also receive disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments in accordance with 89 Ill. Adm. Code 148.290, if applicable.~~

~~b) Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:~~

~~1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(c).~~

~~2) The appropriate outlier payment amounts determined under Section 149.105.~~

~~3) Capital related costs as determined under subsection (c)(1)(A) of this Section.~~

~~e) Payments for Capital Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis. Payments for these costs shall be calculated as follows:~~

~~1) Capital Related Costs~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):~~

~~i) The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).~~

~~ii) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~

~~iii) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) above, shall be rank ordered for all hospitals and capped at the 80th percentile.~~

~~iv) Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.~~

~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):~~

~~i) Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) of this Section.~~

~~ii) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) of this Section, whichever is less.~~

~~2) A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.~~

~~d) Method of Payment~~

~~1) General Rule. Unless the provisions of subsection (d)(2) of this Section apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).~~

~~2) Special Interim Payment for Unusually Long Lengths of Stay~~

~~A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.~~

~~B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A) of this Section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection~~

~~(d)(2).~~

~~3) Outlier Payments. Except as provided in subsection (d)(2) of this Section, payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.~~

~~e) Reductions to Total Payments~~

~~1) Copayments. Copayments are assessed in accordance with 89 Ill. Adm. Code 148.190.~~

~~2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

~~f) Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies: Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) of this Section, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.~~

~~1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.~~

~~2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hospital Reimbursement Changes

2) Code Citation: 89 Ill. Adm. Code 152

3)

Section Numbers:	Proposed Action:
152.100	Amend
152.150	Amend
152.200	Repeal
152.300	Amend

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Save Medicaid Access and Resources Together (SMART) Act [305 ILCS 5/14-11]

5) A Complete Description of the Subjects and Issues Involved: This rulemaking is required pursuant to the Save Medicaid Access and Resources Together (SMART) Act, which created 305 ILCS 5/14-11 and required the Department to implement hospital payment reform.

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

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

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

9) Does this rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: This rulemaking does affect units of local government. It will have an impact on county government entities that own or operate nursing facilities enrolled in the Medical Assistance Program.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@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].

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: Providers will have to report on Potentially Preventable Readmissions.

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2014

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

PART 152
HOSPITAL REIMBURSEMENT CHANGES

Section
152.100 Hospital Rate Reductions
152.150 Hospital Payment Documentation and Coding Improvement Adjustment~~Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)~~
152.200 Non-DRG Reimbursement Methodologies (Repealed)
152.250 Appeals (Repealed)
152.300 Adjustment for Potentially Preventable Readmissions

AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Sections 12-13 and 14-8 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and Sections 12-13 and 14-8].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2150, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10141, effective June 17, 1994; emergency amendment at 19 Ill. Reg. 6706, effective May 12, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10236, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16272, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9272, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15712, effective November 27, 1996; emergency amendment at 21 Ill. Reg. 9544, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16153, effective November 26, 1997; emergency amendment at 25 Ill. Reg. 218, effective January 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6966, effective May 28, 2001; emergency amendment at 25 Ill. Reg. 16122, effective December 3, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 7309, effective April 29, 2002; emergency amendment at 29 Ill. Reg. 10299, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19997, effective November 23, 2005; emergency amendment at 30 Ill. Reg. 11847, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18703, effective November 27, 2006; emergency amendment at 32 Ill. Reg. 529, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8730, effective May 29, 2008; amended at 35 Ill. Reg. 10114, effective June 15, 2011; emergency amendment at 36 Ill. Reg. 10410, effective July 1, 2012 through June 30, 2013; emergency amendment at 37 Ill. Reg. 282, effective January 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10517, effective June 27, 2013; emergency amendment at 37 Ill. Reg. 13589, effective August 1, 2013,

for a maximum of 150 days; emergency amendment at 37 Ill. Reg. 16003, effective September 27, 2013, for a maximum of 150 days; amended at 38 Ill. Reg. 882, effective December 23, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 152.100 Hospital Rate Reductions

Notwithstanding any provision to the contrary in 89 Ill. Adm. Code 148 and 149 and this Part 152, effective for dates of service on or after July 1, 2012, any rate of reimbursement for services to hospitals or other payments to hospitals shall be reduced by an additional 3.5% from the rates that were otherwise in effect on July 1, 2012, and with implementation of SMART hospital payment reform rates in effect on July 1, 2014, except that those reductions shall not apply to:

a) Rates or payments for hospital services delivered by ~~a hospital defined as~~ a Safety Net Hospital under Section 5-5e.1 of the Illinois Public Aid Code [305 ILCS 5].

b) Rates or payments for hospital services delivered by ~~a hospital defined as~~ a Critical Access Hospital as defined in 89 Ill. Adm. Code 148.25(g). ~~that is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, subpart F.~~

c) Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or State university that provides some or all of the non-federal share of the services.

d) Payments authorized under Section 5A-12.4 of the Illinois Public Aid Code.

e) Transitional payment authorized in 89 Ill. Adm. Code 148.296.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 152.150 Hospital Payment Documentation and Coding Improvement Adjustment~~Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)~~

Effective for dates of service on or after July 1, 2014:

a) Inpatient Hospital Payment Documentation and Coding Improvement (DCI) Adjustment ~~Notwithstanding any provisions set forth in 89 Ill. Adm. Code 149, the changes described in subsections (b) and (c) of this Section will be effective January 18, 1994.~~

1) The Department shall monitor changes in inpatient hospital statewide average case mix for services provided in the first two years following implementation of the APR-DRG payment methodology, and retrospectively adjust DRG base rates to offset the impact of paid case mix differential attributable to DCI.

2) Measuring case mix differential attributable to DCI:

A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the Medicare-Severity DRG (MS-DRG) grouper and relative weights for:

i) Claims with dates of service in State fiscal year 2011.

ii) Claims with dates of service in State fiscal years 2015 and 2016, consistent with subsection (a)(3).

B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the APR-DRG weighting factors for the same periods specified in subsection (a)(1)(A).

C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate APR-DRG case mix and the change in the aggregate MS-DRG case mix for the claims described in subsection (a)(1)(A).

D) Claims for services provided in State fiscal years 2015 and 2016 that were not paid by the Department using the APR-DRG payment methodology shall be excluded when measuring the case mix differential.

3) Timing:

A) Calculate case mix differential attributable to DCI for claims with Dates of Service (DOS) in SFY 2015 (first year of implementation) as of:

i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.

ii) January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

iii) April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

B) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:

i) July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.

ii) January 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

iii) April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

4) Adjusting for case mix changes attributable to DCI:

A) For any measurement period described in subsection (a)(3), if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the DRG base rates by the measured case mix differential less two percentage points.

B) For any measurement period described in subsection (a)(3), if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the DRG base rates by the measured case mix differential plus two percentage points.

C) The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the DRG base rates.

b) Outpatient Hospital Payment Documentation and Coding Improvement

Adjustment ~~For the rate periods, as described in 89 Ill. Adm. Code 148.25(g)(2)(B), the DRG weighting factors shall be adjusted by a factor, the numerator of which is the statewide weighted average DRG base payment rate in effect for the base period, as described in 89 Ill. Adm. Code 148.25(g)(2)(A), and the denominator of which is the statewide weighted average DRG base payment rate for the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(B). For this adjustment, DRG base payment rate means the product of the PPS base rate, as described in 89 Ill. Adm. Code 149.100(c)(3), and the indirect medical education factor, as described in 89 Ill. Adm. Code 149.150(c)(3).~~

1) The Department shall monitor changes in outpatient hospital case mix for services provided in the first two years following implementation of the Enhanced Ambulatory Procedure Grouping (EAPG) payment methodology, and retrospectively adjust EAPG conversion factors to offset the impact of the case mix differential attributable to DCI.

2) Measuring case mix differential attributable to DCI:

A) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Ambulatory Procedures List (APL) relative values for the claims data periods listed in this subsection (b)(2)(A). Relative values will be determined for each APL using SFY 2011 outpatient claims data by dividing the APL's average payment per service unit by the statewide APL payment for service unit.

i) Claims with DOS in SFY 2011.

ii) Claims with DOS in SFY 2015 and 2016, consistent with subsection (b)(3).

B) Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 3.7 of the EAPG grouper and the EAPG weighting factors for the same periods.

C) The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate EAPG case mix

and the change in the aggregate APL case mix, for the claims described in subsections (b)(2)(A)(i) and (ii).

D) Claims for services provided in SFY 2015 and 2016 that were not paid by the Department using the EAPG payment methodology shall be excluded when measuring the case mix differential.

3) Timing:

A) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2015 (first year of implementation) as of:

i) July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.

ii) January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

iii) April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

B) Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:

i) July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.

ii) January 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

iii) April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

4) Adjusting for case mix changes attributable to DCI:

A) For any measurement period described in subsection (b)(3), if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the EAPG

conversion factor by the measured case mix differential less two percentage points.

B) For any measurement period described in subsection (b)(3), if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential plus two percentage points.

C) The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the EAPG conversion factors.

D) The EAPG conversion factor, after adjustments pursuant to subsections (b)(4)(A) and (B), shall be in effect until the next measurement period.

~~c) All payments calculated under 89 Ill. Adm. Code 149.140 and 149.150(c)(1), (c)(2) and (c)(4), in effect on January 18, 1994, shall remain in effect hereafter.~~

~~d) For hospital inpatient services rendered on or after July 1, 1995, the Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated pursuant to the methodology described in this Section, that were in effect on June 30, 1995, less the portion of such rates attributed by the Department to the cost of medical education.~~

~~e) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 149 (DRG PPS), the changes described in this subsection (e) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 149.105 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).~~

~~f) Notwithstanding the provisions of 89 Ill. Adm. Code 149, payment for outlier cases pursuant to 89 Ill. Adm. Code 149.105 shall be determined by using the following factors that were in effect on June 30, 1995:~~

~~1) The marginal cost factor (see 89 Ill. Adm. Code 149.5(c)(4)),~~

~~2) The Metropolitan Statistical Area (MSA) wage index (see 89 Ill. Adm. Code 148.120(b)),~~

~~3) The Indirect Medical Education (IME) factor (see 89 Ill. Adm. Code 148.260(a)(1)(B)(iv)),~~

~~4) The cost to charge ratio (see 89 Ill. Adm. Code 149.105(c)(3)), and~~

~~5) Outlier Threshold~~

~~A) For admissions on December 3, 2001 through June 30, 2005, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.22.~~

~~B) For admissions on or after July 1, 2005 through June 30, 2006, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.40.~~

~~C) For admissions on or after July 1, 2006 through December 31, 2007, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.47.~~

~~D) For admissions on or after January 1, 2008, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.64.~~

~~E) For admissions on or after January 1, 2011, the cost outlier threshold (see 89 Ill. Adm. Code 149.5(c)(5)) multiplied by 1.99.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 152.200 Non-DRG Reimbursement Methodologies (Repealed)

~~a) Notwithstanding any provisions set forth in 89 Ill. Adm. Code 148, the changes described in subsection (b) of this Section will be effective January 18, 1994.~~

~~b) All per diem payments calculated under 89 Ill. Adm. Code 148, except for those~~

~~described in 89 Ill. Adm. Code 148.120, 148.160, 148.170, 148.175 and 148.290(a), (c) and (d), in effect on January 18, 1994, less the portion of such rates attributed by the Department to the cost of medical education, shall remain in effect hereafter.~~

~~c)~~ ~~Notwithstanding the provisions set forth in 89 Ill. Adm. Code 148, Hospital Services, and 89 Ill. Adm. Code 146, Subpart A, Ambulatory Surgical Treatment Centers, the changes described in this subsection (c) shall be effective January 1, 2001. Payments for hospital inpatient and outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals or children's hospitals as defined at 89 Ill. Adm. Code 149.50(c)(3). This payment limitation shall not apply to or affect disproportionate share payments as described at 89 Ill. Adm. Code 148.120, payments for outlier costs as described at 89 Ill. Adm. Code 148.130 or payments for Medicaid High Volume Adjustments as described at 89 Ill. Adm. Code 148.290(d).~~

~~d)~~ ~~Notwithstanding the provisions of subsections (a), (b) and (c) of this Section, payment for outlier adjustments provided for exceptionally costly stays pursuant to 89 Ill. Adm. Code 148.130 shall be determined using the following factors:~~

~~1)~~ ~~For admissions on December 3, 2001 through June 30, 2005, a factor of 0.22 in place of the factor 0.25 described at 89 Ill. Adm. Code 148.130(b)(3)(D).~~

~~2)~~ ~~For admissions on or after July 1, 2005 through June 30, 2006, a factor of 0.20 in place of the factor 0.22 as described in subsection (d)(1) of this Section.~~

~~3)~~ ~~For admissions on or after July 1, 2006 through December 31, 2007, a factor of 0.18 in place of the factor 0.20 as described in subsection (d)(2) of this Section.~~

~~4)~~ ~~For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described in subsection (d)(3) of this Section.~~

~~e)~~ ~~Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer~~

~~Program Act [210 ILCS 155], effective July 1, 2012, shall be the amount in effect as of October 1, 2010. The July 1, 2012 rate will then be subject to the rate reductions detailed in Section 152.100. No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.~~

~~f)~~ ~~Notwithstanding any other provisions of 89 Ill. Adm. Code 148 or 149 or this Part, a hospital that is located in a county of the State in which the Department mandates some or all of its beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as defined in Section 5-30 of the Public Aid Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of the Public Aid Code that it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital as defined in 89 Ill. Adm. Code 148.295(g)(5), no later than August 14, 2012 or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care Program.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 152.300 Adjustment for Potentially Preventable Readmissions

a) Notwithstanding any provision set forth in 89 Ill. Adm. Code 148 or 149 and unless otherwise stated in this Section, the changes described in this Section will be effective January 1, 2013.

b) For clean claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of readmissions, as defined in accordance with the criteria set forth in subsection (d), as determined by a risk adjusted comparison of the actual and targeted number of readmissions in a hospital as described by subsection (e), shall be reduced in accordance with subsection (f).

c) Definitions. For purposes of this Section, the following terms are defined in this subsection (c). For State fiscal year 2013, the Potentially Preventable Readmission (PPR) methodology, version 27 of the definitions manual applicable to the 3M Potentially Preventable Readmissions Grouping Software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Readmission. This version is available by registering at the following link:

https://support.3mhis.com/app/answers/detail/a_id/4133/kw/PPR. For the State fiscal year 2014 PPR methodology, version 29 of the definitions manual applicable to the PPR software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Admission. This version is available by registering at the link referenced above. Beyond State fiscal year 2014, the version that the Department will utilize will be updated in rule as soon as the information becomes available to the Department. Except when other definitions and criteria applicable to PPR are specified in this Section, the methodology applied by the 3M PPR Grouping Software and contained in the Potentially Preventable Readmissions Classification System Methodology Overview (GRP-139, May 2008, no later amendments or editions included) published by 3M Health Information Systems, 575 West Murray Blvd., Salt Lake City UT 84123, and accessible at http://www2.illinois.gov/hfs/SiteCollectionDocuments/3MPotentiallyPreventableReadmissions.pdf, is incorporated by reference.

1) "Potentially Preventable Readmission" or "PPR" shall mean a readmission meeting the readmission criteria in subsection (d) that follows a prior discharge from a hospital within 30 days and that is clinically-related to the prior hospital admission.

2) "Hospital" shall mean a hospital as defined in 89 Ill. Adm. Code 148.25(b).

3) "Base Year" shall mean State fiscal year 2010 and it is the initial data year the Department used to calculate the statewide average PPR rate. Each hospital Current Year is compared to the Base Year to measure the hospital's PPR performance over time.

4) "Current Year" shall mean the State fiscal year in which Targeted Rate of Readmission is set for hospitals to achieve their Targeted Rates of Readmission.

5) "Data Year" shall mean the most recent fully adjudicated claims data in a State fiscal year available to the Department, which is used to calculate the Actual Rate of Readmission and the Targeted Rate of Readmission for each hospital.

6) "Clean Claim" shall mean a claim as defined in 42 CFR 447.45(b).

7) "Clinically Related" shall mean that the underlying reason for readmission is plausibly related to the care rendered during a prior hospital admission. A clinically-related readmission results from the process of care and treatment provided during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post-admission follow up (e.g., lack of follow-up care arrangements with a primary physician) rather than from unrelated events that occurred after the prior admission (such as a broken leg due to trauma) within a specified readmission time interval.

8) "Initial Admission" shall mean an admission to a hospital that is followed by a subsequent readmission or readmissions within 30 days that are determined by the 3M Corporation's PPR methodology to be clinically related.

9) "Only Admission" shall mean an admission without an associated readmission.

10) "Potentially Preventable Readmission Chain" or "PPR Chain" shall mean an initial admission occurring at a hospital that is followed by one or more clinically-related PPRs. The PPRs may occur at the same hospital or a different hospital.

11) "Qualifying Admission" shall mean the number of PPR Chains plus the number of "Only Admissions", but specifically excludes the admissions detailed in subsection (d)(2).

12) "Actual Rate" shall mean the number of PPR Chains for a hospital divided by the total number of qualifying admissions for the hospital.

13) "Targeted Rate of Readmissions" shall mean a risk adjusted readmission rate for each hospital that accounts for the severity of illness, APR-DRG, presence of behavioral health issues, and age of patient at the time of discharge preceding the readmission.

14) "Excess Rate of Readmission" shall mean the difference between the actual rate of readmission and the targeted rate of readmission for each hospital.

15) "Behavioral Health", for the purposes of risk adjustments, shall mean an admission that includes a secondary diagnosis of a major behavioral health related condition, including, but not limited to, mental disorders, chemical dependency and substance abuse.

16) As of August 1, 2013, "Pediatric/Behavioral Health Factor" shall mean a factor that is a calculation of PPR for both children and adults with and without a secondary diagnosis of Behavioral Health. This is a risk adjustment factor. This factor is multiplied by a hospital's Actual Rate of PPR at the service level before it is compared to the statewide average rate of PPR in order to calculate the hospital's Actual Rate of readmission. There are three categories of factors that are calculated and within each category there are three factors that are calculated for a total of nine factors. The categories include pediatric at a non-Tier I PICU Facility, a pediatric at a Tier I PICU Facility and an adult. Within each category, the three factor calculations include a primary diagnosis of non-behavioral health with no presence of behavioral health, a primary diagnosis of non behavioral health with a secondary diagnosis of behavioral health and a primary diagnosis of behavioral health. For example, Tier I PICU Facilities treat higher acuity children and therefore have a higher expected rate of readmission than those children with the same diagnosis treated at the non-Tier I PICU Facilities. By applying this factor, it risk-adjusts the hospital's PPR rate to account for the variance in readmission rates for the different categories.

17) As of August 1, 2013, "Tier I Pediatric Intensive Care Unit" or "PICU" shall mean, a hospital that is either freestanding or has a Distinct Part Unit having pediatric trauma units and provides two or three of the following sets of procedures: pediatric transplants, Extracorporeal Membrane Oxygenation (ECMO), and complex pediatric cardiac surgeries.

d) Readmission Criteria

1) A readmission is defined as an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR software created and maintained by the 3M Corporation, and meets all of the following criteria:

A) The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, in the prior discharge or during the post-discharge follow-up period.

B) The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.

C) The PPR Chain may have one or more readmissions that are clinically related to the Initial Admission. The first readmission is within 30 days after the Initial Admission, but the 30 day timeframe begins again at the discharge of either the Initial Admission or the most recent readmission clinically related to the Initial Admission. For example, a patient is discharged after being admitted for back surgery and readmitted two weeks after the discharge for a post-operation infection that is clinically related to the back surgery. The 30 day period begins again at the discharge for the post-operation infection. However, if the patient is readmitted for a broken leg within 30 days after the post-operation infection, there is no clinical relationship and therefore not considered a PPR. Should a readmission occur within 30 days that is clinically related to the broken leg, then that would create a new PPR Chain separate from the back surgery.

D) The readmission is to the same or to any other hospital.

2) Admissions data, for the purposes of determining PPRs, excludes the following circumstances:

A) The discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of the discharge and readmission are documented in the patient's medical record.

B) The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, certain HIV APR DRGs (listed in the version of the 3M definitions manual applicable to the State fiscal year in question), alcohol or drug detoxification, non-acute events

(rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code 148.25(d)(4)~~149.50(c)(4)~~, admissions with an APR-DRG code other than 740 through 760.

C) The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Medicaid Managed Care Entity (MCE)~~Managed Care Organization (MCO)~~.

D) As of August 1, 2013, effective for fiscal year 2014, admissions for children defined as less than the age of 19 that have a primary diagnosis at discharge for Behavioral Health. Children treated for an acute service, but who have a secondary diagnosis of Behavioral Health are still included in the analysis, but the Pediatric/Behavioral Health Factor is applied.

3) Non-events are admissions to a non-acute care facility, such as a nursing home, or an admission to an acute care hospital for non-acute care or transfers from one acute hospital to another. Non-events are ignored and are not considered to be readmissions.

4) Planned readmissions, as defined by 3M's team of clinicians, are accounted for in the 3M PPR software as an "Only Admission" and are not considered to be readmissions.

e) Methodology to Determine Excess Readmissions

1) State fiscal year 2013

A) Rate adjustments for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009 and June 30, 2010.

B) Except as otherwise provided in subsection (f)(8), the targeted rate of readmission for each hospital shall be reduced by the percent necessary to achieve a savings of at least $40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in 89 Ill. Adm. Code 148.25(a)~~148.458(a)~~.

C) Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs, as adjusted in subsection (e)(1)(B).

D) In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.

2) Effective August 1, 2013 for State fiscal year 2014 and thereafter.

A) The Targeted Rate of Readmission for the Current Year 2014 shall be based on the inpatient hospital medical assistance services provided in the Data Year 2011 for admissions that occurred between July 1, 2010 and June 30, 2011. The Data Year will be updated one year for determining the Targeted Rate of Readmission for each Current Year thereafter.

B) The average statewide expected rate of readmission will be multiplied by .85 for acute services and .90 for Behavioral Health Services. This multiplication factor sets a goal that is specific to each hospital that lowers the Target Rate of Readmission rather than maintaining the statewide average.

C) A Pediatric/Behavioral Health Factor is applied to those services provided at a Tier I PICU to account for the higher PPR rate for the higher acuity children.

D) Excess readmissions for each hospital shall be calculated by subtracting the actual number of PPR Chains from the targeted number of PPR Chains as adjusted in subsection (e)(2)(B) and (e)(2)(C).

E) In the event the actual number of PPR Chains for a hospital is lower than the targeted number of PPR Chains, the excess number of readmissions shall be set at zero.

f) Payment Reduction Calculation for State fiscal year 2013

1) An average readmission payment per PPR Chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR Chains (excluding the liability associated with the initial admission) by the number of PPR Chains for the hospital.

2) The total excess readmission payments shall equal the average readmission payment per PPR Chain, as determined in subsection (f)(1) multiplied by the number of PPR Chains above the target as determined in subsection (e)(1)(C).

3) The total annual payment reduction for each hospital shall be the lesser of:

   A) The total excess readmission payments as determined in subsection (f)(2); or

   B) The total medical assistance payments for all hospital admissions, including admissions that were excluded from the PPR analysis, multiplied by 7%.

4) A fiscal year 2013 hospital specific payment reduction factor for each hospital shall be computed as one minus the arithmetic operation of 25% of the total annual payment reduction, as determined in subsection (f)(3), divided by 50% of the total estimated medical assistance payments for all hospital clean claims received in fiscal year 2013.

5) The hospital specific payment reduction factor, as determined in subsection (f)(4), shall be applied to the final payment amount for each clean claim received in fiscal year 2013.

6) In order to achieve a savings of 25% of the annual payment reduction for each hospital, the hospital specific payment reduction factor may be adjusted to account for variances between the estimated payments to the hospital and the actual payments to the hospital.

7) For those hospitals that have a payment reduction amount in State fiscal year 2013, a reconciliation of fiscal year 2013 claims will be calculated after January 1, 2014, after all inpatient hospital claims have been received by the Department, to determine how much of the remaining annual

payment reduction must be recovered from the hospital. This reconciliation will determine how much of the annual payment reduction was offset in fiscal year 2013 by comparing the fiscal year 2013 rate of readmission to the base year (fiscal year 2010), as determined by subsection (e)(1)(B). In addition, the reconciliation will account for changes in the average readmission payment per PPR Chain from fiscal year 2010 to fiscal year 2013.

8) After the Department verifies that all hospitals have achieved $40 million savings in aggregate for FY2013 when compared to the base year, no further payment reductions will be applied to individual hospitals.

g) Effective August 1, 2013, Payment Penalty Calculation for State Fiscal Year 2014 and Thereafter

1) An average readmission penalty payment per PPR Chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR Chains (excluding the liability associated with the initial admission) by the number of PPR Chains for the hospital.

2) The total excess readmission penalty payments shall equal the average readmission payment per PPR Chain, as determined in subsection (g)(1) multiplied by the number of PPR Chains above the target as determined in subsection (e)(2)(D).

3) The total annual payment penalty for each hospital shall be the lesser of:

A) The total excess readmission payments as determined in subsection (g)(2); or

B) The total inpatient medical assistance payments per hospital, including admissions that were excluded from the PPR analysis (that includes all static and assessment payments net of the annual assessment tax), multiplied by 3%.

4) Prior to collection of the payment penalty, an analysis will be conducted of the Current Year data to determine if any of the payment penalty was cost avoided. Once the Current Year is complete and all inpatient hospital

claims data has been received and adjudicated by the Department, the Department will calculate the hospital's Actual Rate of Readmission using the same version of the PPR software that was used to calculate the Base Year. A comparison of the Base Year to the Current Year will be done to see if hospitals were able to reduce their readmissions and their average cost per PPR Chain.

A) The payment penalty can be cost avoided in full if a hospital lowers its Actual Rate to at or below its Targeted Rate of Readmission.

B) Hospitals that did not meet their Targeted Rate of Readmission but lowered their Actual PPR rate can have a portion of their payment penalty cost avoided. In order to have a portion of the payment penalty cost avoided, hospitals must reduce the variance between their Actual Rate and their Targeted Rate of Readmission and lower their average medical assistance payment per PPR Chain for the Current Year.

C) Based on the analysis performed in subsection (g)(4)(B), hospitals that are able to reduce their readmissions compared to the Base Year will have the cost avoided amount deducted from their payment penalty.

D) Should a hospital have a higher rate of readmission when compared to the Base Year, the payment penalty will not be more than the original amount calculated.

E) If an aggregate application of the cost avoidance calculation shows that hospitals have reduced the cost of readmissions for the Current Year when compared to the Base Year by more than the total payment penalty owed by all hospitals, then payment penalties will not be charged to any hospital for that year. This aggregate calculation must factor in the hospitals that performed worse in the Current Year.

5) After the application of any cost avoidance pursuant to subsection (g)(4), hospitals will pay 50% of the remaining payment penalty to the

Department. This amount shall be paid in 12 equal installments beginning on July 1, of the next fiscal year.

6) Hospitals that are delinquent in paying any amounts due will have adjustments applied to future claims until the full amount of the payment penalty due has been recouped.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Improper Claims Practice

2) Code Citation: 50 Ill. Adm. Code 919

3)

Section Numbers:	Proposed Action:
919.40	Amend
919.EXHIBIT A	Amend

4) Statutory Authority: Implementing Sections 154.5 and 154.6 of the Illinois Insurance Code [215 ILCS 5/154.5 and 154.6] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401], Section 10 of the Voluntary Health Services Plans Act [215 ILCS 165/10], Section 65 of the Dental Service Plan Act [215 ILCS 110/65] and Section 5-3 of the Health Maintenance Organization Act [215 ILCS 125/5-3]

5) A Complete Description of the Subjects and Issues Involved: This rulemaking updates Department contact information.

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

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

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

9) Does this rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: 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:

James Rundblom Deputy General Counsel
Department of Insurance
320 West Washington, 4th Floor

or

Susan Anders, Rules Coordinator
Department of Insurance
320 West Washington, 4th Floor

Springfield IL 62767-0001

217/785-8559
fax: 217/524-9033

Springfield IL 62767-0001

217/558-0957

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: Insurance claim handling procedures as set forth throughout the rule

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: July 2013

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

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER l: PROVISIONS APPLICABLE TO ALL COMPANIES

PART 919
IMPROPER CLAIMS PRACTICE

Section

919.10 Authority
919.20 Scope and Purpose
919.30 Examinations
919.40 Definitions/Explanations
919.50 Required Practices for all Insurance Companies
919.60 Improper Practices or Procedures for all Insurance Companies
919.70 Required Claims Practices – Life, Accident and Health Companies
919.80 Required Claim Practices – Private Passenger Automobile – Property and Casualty Companies
919.90 Improper Practices or Procedures – Property and Casualty Companies
919.100 Severability Provision
919.EXHIBIT A Total Loss Automobile Claims

AUTHORITY: Implementing Sections 154.5 and 154.6 of the Illinois Insurance Code [215 ILCS 5/154.5 and 154.6] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401], Section 10 of the Voluntary Health Services Plans Act [215 ILCS 165/10], Section 25 of the Dental Service Plan Act [215 ILCS 110/25] and Section 5-3 of the Health Maintenance Organization Act [215 ILCS 125/5-3].

SOURCE: Filed June 17, 1974, effective July 1, 1974; amended at 2 Ill. Reg. 22, p. 77, effective May 22, 1978; new rules adopted at 3 Ill. Reg. 31, p. 93, effective August 4, 1979; old rules repealed 3 Ill. Reg. 32, p. 42, effective August 6, 1979; emergency amendment and codified at 7 Ill. Reg. 2755, effective February 28, 1983, for a maximum of 150 days; amended and codified at 7 Ill. Reg. 11489, effective October 1, 1983; amended at 10 Ill. Reg. 5125, effective March 17, 1986; amended at 13 Ill. Reg. 1204, effective January 11, 1989; amended at 26 Ill. Reg. 11915, effective July 22, 2002; amended at 27 Ill. Reg. 19287, effective December 10, 2003; amended at 28 Ill. Reg. 9253, effective July 1, 2004; amended at 38 Ill. Reg. _____, effective _____.

Section 919.40 Definitions/Explanations

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Company" means~~refers to~~ any licensee of the Department of Insurance, including health maintenance organizations.

"Days", for the purpose of this Part, means calendar days.

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance.

"Documentation" means ~~shall mean~~ all pertinent communications, transactions, notes and work papers. All such communications, transactions, notes and work papers shall be properly dated and compiled in sufficient detail in order to allow for the reconstruction of all pertinent events relative to each claim file. Documentation shall include but not be limited to bills, explanations of benefits and worksheets.

"First Party" means any individual, corporation, association, partnership, or other legal entity asserting a contractual right to payment under an insurance policy or insurance contract arising out of the contingency or loss covered by the~~such~~ policy or contract.

"Insured" means ~~shall mean~~, for the purposes of life, accident and health insurance or other health care or service plans, the party named on a contract as the individual, corporation or association with legal rights to the benefits provided by the~~such~~ contract. This includes certificate holders or subscribers to a group contract and enrollees of a health maintenance organization, any other type of health care or service plans, or third party administrator. For purposes of property and casualty insurance, the party named on the contract is the insured.

"Non-Original Manufacturer" means any manufacturer other than the manufacturer of the original part.

"Notice of Availability of the Department of Insurance", as required by this Part, shall be no less informative than the following:

> Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the

Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor~~100 W. Randolph Street, Suite 15-100~~, Chicago, Illinois 60603~~60601~~ and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

"Notification of Loss" means ~~shall mean~~ communication, as required by the policy or that is otherwise acceptable by the insurer, from a claimant or insured to the insurer that~~which~~ identifies the claimant or insured and indicates that a loss has occurred or is about to occur.

"Pertinent Communication", as used in Section 154.6(b) of the Code ~~[215 ILCS 5/154.6(b)]~~, means~~shall include~~ all correspondence, regardless of source or type, that is materially related to the handling of the claim.

"Policy", for the purpose of this Part, means~~shall mean~~ a policy, certificate or contract issued to Illinois residents, including a certificate of enrollment into a health maintenance organization or any other type of health care or service plan.

"Private Passenger Automobile" means a vehicle ~~refers to vehicles~~ insured under a policy of automobile insurance as defined in Section 143.13 of the Code ~~[215 ILCS 5/143.13]~~.

"Prompt Investigation", as used in Section 154.6(c) of the Code ~~[215 ILCS 5/154.6(c)]~~, means~~shall apply to~~ all activities of the company related directly or indirectly to the determination of liability based on claims under the coverage afforded by the policy and shall be evidenced by a bonafide effort to communicate with all insureds and claimants when~~where~~ liability is reasonably clear within 21 working days after a notification of loss. Evidence of ~~such~~ bonafide effort to communicate with insureds and claimants shall be maintained in the company's claim files.

"Reasonable Promptness", as used in Section 154.6(b) of the Code~~[215 ILCS 5/154.6(b)]~~, means~~shall mean~~ a maximum of 15 working days from receipt of communication from a claimant or insured.

"Replacement Crash Parts", for purposes of this Part, means sheet metal or synthetic parts, e.g., plastic, fiberglass, etc., that constitute the exterior of a motor vehicle, including inner and outer panels.

"Representative" means ~~shall include~~ any person expressly authorized to act on behalf of the insurer and any employee of the insurer who acts or appears to act on behalf of the insurer in matters relating to claims, including but not limited to independent contractors while performing claim services at the direction of the company.

"Settlement of Claims", as used in Section 154.6(c) of the Code ~~[215 ILCS 5/154.6(c)]~~, shall pertain to all activities of the company or its representatives, relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy. Evidence of those~~such~~ activities shall~~to~~ be maintained in the company's claim files.

"Third Party" refers to any individual, corporation, association, partnership~~,~~ or other legal entity asserting a claim against any individual, corporation, partnership~~,~~ or other legal entity insured under a policy.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

Section 919.EXHIBIT A Total Loss Automobile Claims

1) Total Loss Claims

When you are involved in an automobile accident, one of the first things you may have to do is file a claim for damages to your vehicle. If your car is a total loss, this procedure can sometimes be confusing.

Your automobile insurance policy requires both you and your insurance company to follow certain steps after a loss occurs. This publication summarizes those requirements and outlines your rights.

The Illinois Department of Insurance has established regulations to protect you when you file an insurance claim. It is also important that you read your policy carefully so that you clearly understand your responsibilities.

If you still have questions, you can contact our Consumer Services Section by phone at (866) 445-5364 or at one of the following locations:

320 West Washington Street
Springfield, Illinois 62767
~~(217) 782-7446~~

OR

122 S. Michigan Ave., 19th Floor
~~100 West Randolph Street, Suite 15-100~~
Chicago, Illinois 60603~~60601~~
~~(312) 917-2427~~

2) Your Duties

1. You must immediately report all losses directly to your insurance producer or company.

2. If you suspect theft or vandalism, you must also report it immediately to the police. If you fail to do so, your company may deny your claim.

3. You must protect your automobile from futher damage. For example, if you fail

to cover a broken windshield and the upholstry is damaged by rain, your company can refuse to repair the seat.

4. Most insurance policies require that, within 91 days after the loss, you must submit a sworn proof of loss. A sworn proof of loss usually states the date of loss, how it happened, and for what purpose the automobile was being used. If you fail to submit a proof of loss your company may deny your claim.

5. You must cooperate with the insurance company, submit to examination under oath, if so requested, and show them the damaged property. If you fail to cooperate your company may deny your claim.

6. You should review the Conditions section of your policy for other possible requirements.

3) Your Insurance Company's Duties

When you file an automobile insurance claim, your insurance company has three options:

1) Replace the damaged or stolen property;

2) Repair the damaged property; or

3) Pay for the loss in cash.

Insurance Department regulations require the company to follow certain standards for each option.

4) Replacement

If the insurance company elects to replace your vehicle, the replacement must be a specific make and model comparable to your totalled vehicle, and it must be available in as good or better overall condition than your totalled vehicle.

Replacement vehicles must be purchased through licensed dealers. Vehicles that are no more than three years old must be warranted.

If you reject a replacement vehicle, the insurance company must pay only the amount it would have otherwise paid for the replacement vehicle including applicable taxes,

transfer and title fees. The company must offer you the replacement vehicle and you must reject the offer.

If you desire a replacement vehicle of similar value, this replacement method is also permitted.

5) Cash Settlement

If the insurance company elects to make a cash settlement for your totalled vehicle, they must first determine its retail value. Companies normally use guide books or computerized data marketed by various sources.

If your vehicle is not listed in one of these sources, the company can use written dealer quotes. Ordinarily, however, newspaper advertisements are not acceptable sources of market value.

6) Payment of Sales Tax

If within 30 days of a cash settlement, you can prove that you have purchased another vehicle, the company must pay the applicable sales tax, transfer and title fees in an amount equivalent to the value of the total loss vehicle. If you purchase a vehicle with a market value less than the amount previously settled upon, the company must pay you only the amount of sales tax that you actually incurred and include transfer and title fees.

Your insurance company must give you written notice of this procedure.

7) Betterment Deductions

The insurance company is allowed to make deductions from the retail value if your automobile has old, unrepaired collision damages. There is no limit to the amount of the deduction.

The insurance company can also make deductions for wear and tear, missing parts and rust, but the maximum deduction may not exceed $500.00.

All deductions must be itemized and specified as to dollar amount.

8) Retaining Your Totalled Vehicle

In an effort to minimize automobile "chop shop" crime, the Illinois Vehicle Code does not permit you the right to retain the salvage once your automobile has been deemed a total loss by your insurance company. The insurance company must take possession of the vehicle, if the vehicle is eight model years or newer.

9) Right of Recourse

If you cannot locate a replacement vehicle within 30 days of receiving a cash settlement, you may have some additional rights under your insurance contract.

If you cannot purchase a substantially similar vehicle for the market value determined by the company, but you have located a substantially similar vehicle that costs more, the following procedures~~procedures(s)~~ shall apply.

1) The company shall either pay your the difference between the original settlement and the amount of the substantially similar vehicle which you have located or attempt to purchase this vehicle for you; or

2) The company shall locate a comparable vehicle for you at the market value determined by the company at the time of settlement; or

3) The company shall conclude the loss settlement as provided under the appraisal section of the insurance policy.

Your insurance company must give you written notice of this procedure once your vehicle has been determined a total loss.

This chart should assist you in determining the retail value of your automobile.

Value

Make of Automobile
Model
Engine Size
Type Transmission
(Auto/Standard)
Power Steering
Power Brakes

Power Windows
Air Conditioner
Vinyl Roof
Cruise Control
Tilt Wheel/Telescope Wheel
Power Locks
Power Seats
AM/FM Radio
Stereo/Tape
Rear Defog
Mileage: Low/High
Subtotal
Minus Deductible

Total

The above figure represents an average automobile. Your automobile may be worth more or less than the above figure because of options on the automobile which are not listed in a guide book or because of the excessive wear and tear or old unrepaired damage to the automobile.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: The Coal Mining Act

2) Code Citation: 62 Ill. Adm. Code 140

3) Section Number: 140.30 — Proposed Action: Amend

4) Statutory Authority: Implementing Section 2.02 and 2.12 of the Coal Mining Act [225 ILCS 705/2.02 and 2.12] and PA 88-599, adopted September 1, 1994 [20 ILCS 1905/47]

5) A Complete Description of the Subjects and Issues Involved: This rulemaking updates all methods including sampling, preparation, storage and analysis, extend retention times of samples, clarify reporting guidelines and update pricing schedule for coal processing.

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: Comments on the proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice to:

Julia Lawrence, Legal Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

217/782-6899

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENT

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: This rulemaking was not summarized on the January 2014 Regulatory Agenda because the determination to amend this rulemaking was made after the Agenda was filed.

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

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENT

TITLE 62: MINING
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES~~MINES AND MINERALS~~

PART 140
THE COAL MINING ACT

Section
140.10 Plans to be Submitted to the Department
140.20 Requirement Concerning Removal of Vehicle Wheels, Tires, and Valve Cores
140.30 Coal Quality Testing Program

AUTHORITY: Implementing Sections 2.02 and 2.12 of the Coal Mining Act [225 ILCS 705/2.02 and 2.12] and Section 1905-35 of the Department of Natural Resources (Mines and Minerals) Law [20 ILCS 1905/1905-35].

SOURCE: Adopted May 13, 1975; codified at 8 Ill. Reg. 8509; emergency amendment added at 18 Ill. Reg. 15167, effective October 1, 1994, for a maximum of 150 days; amended at 19 Ill. Reg. 2461, effective February 21, 1995; amended at 38 Ill. Reg. _____, effective _____.

Section 140.30 Coal Quality Testing Program

a) The Department of Natural Resources-Office of Mines and Minerals' (Department) analytical laboratory, located in Benton, Illinois, is authorized to test the quality of coal delivered under State coal purchase contracts.

b) The Department shall analyze samples taken from coal shipments under State contracts provided by any agency or institution of the State of Illinois~~, hereinafter called~~ (the delivering agency), if the ~~such~~ samples are:

1) submitted ~~in the 6 pound increments required for analysis,~~ with a minimum of 6 pounds ~~of coal per sample bag~~ and a maximum of 42 pounds of coal per sample bag ~~(any variation to this sampling process must follow guidelines set by ASTM Standard D-2234-89 found at pp. 270-281 in Volume 05.05 of the 1993 Book of ASTM Standards, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103)~~;

2) identified as having been submitted by a specific delivering agency;

3) received by the Department's Benton, Illinois analytical laboratory by the 10th day of the month; and

4) collected as required by current ASTM Standards for the collection of a gross sample of coal~~Standard D-2234-89 found at pp. 270-281 in Volume 05.05 of the 1993 Book of ASTM Standards, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103~~.

c) The Department shall grind all acceptable coal sample bags from a delivering agency during the third week of the month~~Upon receiving an acceptable sample bag from a delivering agency, the Department shall grind the coal~~ to the specifications of current ASTM Standards for preparing coal samples for analysis with the deviation of storing a minimum of 500 grams of composited 8 mesh sample for repeat analysis if requested.~~Standard D-2013-86 found at page 245 in Volume 05.05 of the 1993 Book of ASTM Standards, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103, by using a hammermill crusher or equivalent device, as follows:~~

~~1) The crusher shall be completely enclosed to avoid the loss of dust or moisture.~~

~~2) The coal in each sample bag shall be mixed (ground by crusher) to form an initial composite sample as stated in ASTM Standard D-2013-86 found at page 245 in Volume 05.05 of the 1993 Book of ASTM Standards, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103.~~

~~3) The initial composite sample shall be reduced to 1,000 grams and divided into two (2) 500 gram samples. The Department shall then dry one of the 500 gram samples to the specifications outlined in ASTM Standard D-2013-86 found at page 247 in Volume 05.05 of the 1993 Book of ASTM Standards, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103. After drying, this 500 gram sample shall then be processed in accordance with subsection (c)(4) below. The undried 500 gram sample shall be held in reserve should more than one test be required.~~

~~4) The 500 gram sample used for immediate analysis shall be placed on a spin wheel mixer for 15 minutes, then analyzed for percent of moisture, percent of ash, percent of sulphur and BTUs, in accordance with subsection (d) below.~~

d) The Department shall perform a short proximate analysis on the 60 mesh coal~~analyze the 500 gram~~ sample using testing procedures that conform to~~ the following specifications found in Volume 05.05 of the 1993 Book of~~ current ASTM Standards.~~, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103:~~

~~1) ASTM Standard D-3302-91 (percent of moisture), pp. 358-364;~~

~~2) ASTM Standard D-3174-89 (percent of ash), pp. 324-326;~~

~~3) ASTM Standard D-4239-93 (percent of sulphur), pp. 392-400; and~~

~~4) ASTM Standard D-1989-92 (BTUs), pp. 237-244.~~

e) The results of the analysis shall be reported to the delivering agency in accordance with subsection (f)~~ below~~. The Department shall retain the undried 500 gram sample for 90~~30~~ days from the date the results of the analysis are sent to the delivering agency.

f) The Department shall report the results of its coal quality analysis to the delivering agency by the end of the month in which it is processed~~within two weeks after the Department's receipt of a coal sample acceptable for testing,~~ and will submit a bill for the coal quality analysis performed, based upon the following schedule:

Analysis of composited sample	$100
Compositing of a gross sample	$25
Exceeding 50 lbs in a bag of coal	$25

~~Number of sample bags tested per month~~	~~Fee~~
~~1 to 2 bags~~	~~$ 50~~
~~3 to 4 bags~~	~~$ 65~~

~~5 to 6 bags~~	~~$ 80~~
~~7 to 8 bags~~	~~$ 95~~
~~9 to 10 bags~~	~~$105~~
~~11 to 12 bags~~	~~$120~~
~~13 to 14 bags~~	~~$135~~
~~15 to 16 bags~~	~~$150~~
~~For every 2 additional bags~~	~~$ 15~~

g) The Department shall process~~charge $50.00 extra for~~ each sample bag submitted by a delivering agency after the 10th day of the month as a new sample at the rates established in subsection (f).

h) References in this Section to current~~the 1993 Book of~~ ASTM Standards refer to the current annual book of ASTM Standards, Fossil Fuels Section, Coal and Coke Volume; published by the American Society for Testing and Materials, ASTM International, 100 Barr Harbor Drive, P.O. Box C700, West Conshohocken PA 19428-2959~~, published by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103, do not include any subsequent amendments or editions~~.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hazardous Waste Management System: General

2) Code Citation: 35 Ill. Adm. Code 720

3)

Section Numbers:	Proposed Action:
720.110	Amend
720.111	Amend

4) Statutory Authority: 415 ILCS 5/7.2, 13, 22.4, and 27

5) A Complete Description of the Subjects and Issues Involved: The following briefly describes the subjects and issues involved in the docket R14-13 rulemaking of which this rulemaking is a single segment. Also affected is 35 Ill. Adm. Code 721, which is covered by a separate notice in this issue of the *Illinois Register*. A comprehensive description is contained in the Board's opinion and order of February 6, 2014, proposing amendments in docket R14-13, which opinion and order is available from the address below.

This proceeding updates the Illinois Resource Conservation and Recovery Act (RCRA) Subtitle C hazardous waste rules to correspond with amendments adopted by the USEPA that appeared in the Federal Register during a single update period. The docket and time period that is involved in this proceeding is the following:

R14-13 Federal RCRA Subtitle C hazardous waste amendments that occurred during the period July 1, 2013 through December 31, 2013.

The R14-13 docket amends rules in Parts 720 and 721. The amendments to the various Parts are inter-related. The following briefly summarizes the federal action in the update period:

July 31, 2013 (78 Fed. Reg. 46448)	Conditional exclusions of solvent-contaminated wipes from the definitions of solid waste and hazardous waste.

In addition to the federal actions that fall within the timeframe of this docket, the Board included one additional federal action that occurred later. This additional action directly impacted one of the actions that USEPA took within the timeframe that is involved.

January 3, 2014 (79 Fed. Reg. 350)	Conditional exclusion from regulation as hazardous waste for carbon dioxide streams injected into a Class VI carbon sequestration well.

Specifically, the rulemaking to Part 720 implement segments of the federal amendments of July 31, 2013 and January 3, 2014. The amendments add definitions and one incorporation by reference that support the exclusions. The Board has included a limited number of corrections and clarifying amendments that are not directly derived from the instant federal amendments. The Board has also included amendments proposed in the pending consolidated update docket, UIC Update, USEPA Amendments (January 1, 2013 through June 30, 2013), R14-1, RCRA Subtitle D (Municipal Solid Waste Landfill) Update, USEPA Amendments (January 1, 2013 through June 30, 2013), R14-2, and RCRA Subtitle C (Hazardous Waste) Update, USEPA Amendments (January 1, 2013 through June 30, 2013), R14-3 (Dec. 5, 2013), which the Board is voted to adopt on February 6, 2014, but which will not be filed until after publication of the present amendments. A table in the Board's opinion and order in docket R14-13 itemizes the amendments from consolidated docket R14-1/R14-2/R14-3.

Tables appear in the Board's opinion and order of February 6, 2014 in docket R14-13 that list numerous corrections and amendments that are not based on current federal amendments. The tables contain deviations from the literal text of the federal amendments underlying these amendments, as well as corrections and clarifications that the Board made in the base text involved. Persons interested in the details of those corrections and amendments should refer to the February 6, 2014 opinion and order in docket R14-13.

Section 22.4 of the Environmental Protection Act [415 ILCS 5/22.4] provides that Section 5-35 of the Administrative Procedure Act [5 ILCS 100/5-35] does not apply to this rulemaking. Because this rulemaking is not subject to Section 5-35 of the APA, it is not subject to First Notice or to Second Notice review by the Joint Committee on Administrative Rules (JCAR).

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

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

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

9) Do these proposed rulemakings contain incorporations by reference? Yes

10) Statement of Statewide Policy Objectives: These proposed amendments do not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

11) Are there any other rulemingings pending on this Part? Yes

Section Number	Proposed Action	*Illinois Register* Citation
720.111	Amend	37 Ill. Reg. 20003, December 20, 2013

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: The Board will accept written public comment on this proposal for a period of 45 days after the date of this publication. Comments should reference docket R14-13 and be addressed to:

John T. Therriault, Clerk
Illinois Pollution Control Board
State of Illinois Center, Suite 11-500
100 W. Randolph St.
Chicago IL 60601

Please direct inquiries to the following person and reference docket R14-13:

Michael J. McCambridge
Staff Attorney
Illinois Pollution Control Board
100 W. Randolph 11-500
Chicago IL 60601

312/814-6924
e-mail: mccambm@ipcb.state.il.us

Request copies of the Board's opinion and order at 312-814-3620, or download a copy from the Board's Website at http:\\www.ipcb.state.il.us.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities, and not-for-profit corporations affected: This rulemaking may affect those small businesses, small municipalities, and not-for-profit corporations that generate, transport, treat, store, or dispose of hazardous waste. These proposed amendments do not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)]

.

B) Reporting, bookkeeping or other procedures required for compliance: The existing rules and proposed amendments require extensive reporting, bookkeeping and other procedures, including the preparation of manifests and annual reports, waste analyses and maintenance of operating records. These proposed amendments do not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

C) Types of professional skills necessary for compliance: Compliance with the existing rules and proposed amendments may require the services of an attorney, certified public accountant, chemist, and registered professional engineer. These proposed amendments do not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)]

14) Regulatory Agenda on which this rulemaking was summarized: January 2014: published at 37 Ill. Reg. 20463, 20501 (December 20, 2013)

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

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER c: HAZARDOUS WASTE OPERATING REQUIREMENTS

PART 720
HAZARDOUS WASTE MANAGEMENT SYSTEM: GENERAL

SUBPART A: GENERAL PROVISIONS

Section
720.101 Purpose, Scope, and Applicability
720.102 Availability of Information; Confidentiality of Information
720.103 Use of Number and Gender
720.104 Electronic Reporting

SUBPART B: DEFINITIONS AND REFERENCES

Section
720.110 Definitions
720.111 References

SUBPART C: RULEMAKING PETITIONS AND OTHER PROCEDURES

Section
720.120 Rulemaking
720.121 Alternative Equivalent Testing Methods
720.122 Waste Delisting
720.123 Petitions for Regulation as Universal Waste
720.130 Procedures for Solid Waste Determinations and Non-Waste Determinations
720.131 Solid Waste Determinations
720.132 Boiler Determinations
720.133 Procedures for Determinations
720.134 Non-Waste Determinations
720.140 Additional Regulation of Certain Hazardous Waste Recycling Activities on a Case-by-Case Basis
720.141 Procedures for Case-by-Case Regulation of Hazardous Waste Recycling Activities
720.142 Notification Requirement for Hazardous Secondary Materials
720.143 Legitimate Recycling of Hazardous Secondary Materials

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

720.APPENDIX A Overview of Federal RCRA Subtitle C (Hazardous Waste) Regulations (Repealed)

AUTHORITY: Implementing Sections 7.2, 13, and 22.4 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 13, 22.4, and 27].

SOURCE: Adopted in R81-22 at 5 Ill. Reg. 9781, effective May 17, 1982; amended and codified in R81-22 at 6 Ill. Reg. 4828, effective May 17, 1982; amended in R82-19 at 7 Ill. Reg. 14015, effective October 12, 1983; amended in R84-9 at 9 Ill. Reg. 11819, effective July 24, 1985; amended in R85-22 at 10 Ill. Reg. 968, effective January 2, 1986; amended in R86-1 at 10 Ill. Reg. 13998, effective August 12, 1986; amended in R86-19 at 10 Ill. Reg. 20630, effective December 2, 1986; amended in R86-28 at 11 Ill. Reg. 6017, effective March 24, 1987; amended in R86-46 at 11 Ill. Reg. 13435, effective August 4, 1987; amended in R87-5 at 11 Ill. Reg. 19280, effective November 12, 1987; amended in R87-26 at 12 Ill. Reg. 2450, effective January 15, 1988; amended in R87-39 at 12 Ill. Reg. 12999, effective July 29, 1988; amended in R88-16 at 13 Ill. Reg. 362, effective December 27, 1988; amended in R89-1 at 13 Ill. Reg. 18278, effective November 13, 1989; amended in R89-2 at 14 Ill. Reg. 3075, effective February 20, 1990; amended in R89-9 at 14 Ill. Reg. 6225, effective April 16, 1990; amended in R90-10 at 14 Ill. Reg. 16450, effective September 25, 1990; amended in R90-17 at 15 Ill. Reg. 7934, effective May 9, 1991; amended in R90-11 at 15 Ill. Reg. 9323, effective June 17, 1991; amended in R91-1 at 15 Ill. Reg. 14446, effective September 30, 1991; amended in R91-13 at 16 Ill. Reg. 9489, effective June 9, 1992; amended in R92-1 at 16 Ill. Reg. 17636, effective November 6, 1992; amended in R92-10 at 17 Ill. Reg. 5625, effective March 26, 1993; amended in R93-4 at 17 Ill. Reg. 20545, effective November 22, 1993; amended in R93-16 at 18 Ill. Reg. 6720, effective April 26, 1994; amended in R94-7 at 18 Ill. Reg. 12160, effective July 29, 1994; amended in R94-17 at 18 Ill. Reg. 17480, effective November 23, 1994; amended in R95-6 at 19 Ill. Reg. 9508, effective June 27, 1995; amended in R95-20 at 20 Ill. Reg. 10929, effective August 1, 1996; amended in R96-10/R97-3/R97-5 at 22 Ill. Reg. 256, effective December 16, 1997; amended in R98-12 at 22 Ill. Reg. 7590, effective April 15, 1998; amended in R97-21/R98-3/R98-5 at 22 Ill. Reg. 17496, effective September 28, 1998; amended in R98-21/R99-2/R99-7 at 23 Ill. Reg. 1704, effective January 19, 1999; amended in R99-15 at 23 Ill. Reg. 9094, effective July 26, 1999; amended in R00-5 at 24 Ill. Reg. 1063, effective January 6, 2000; amended in R00-13 at 24 Ill. Reg. 9443, effective June 20, 2000; amended in R01-3 at 25 Ill. Reg. 1266, effective January 11, 2001; amended in R01-21/R01-23 at 25 Ill. Reg. 9168, effective July 9, 2001; amended in R02-1/R02-12/R02-17 at 26 Ill. Reg. 6550, effective April 22, 2002; amended in R03-7 at 27 Ill. Reg. 3712, effective February 14, 2003; amended in R03-18 at 27 Ill. Reg. 12713, effective July 17, 2003; amended in R05-8 at 29 Ill. Reg. 5974, effective April 13, 2005; amended in R05-2 at 29 Ill. Reg. 6290, effective April 22, 2005; amended in R06-5/R06-6/R06-7 at 30 Ill. Reg. 2930, effective February 23, 2006; amended in R06-16/R06-17/R06-18 at 31 Ill.

Reg. 730, effective December 20, 2006; amended in R07-5/R07-14 at 32 Ill. Reg. 11726, effective July 14, 2008; amended in R09-3 at 33 Ill. Reg. 922, effective December 30, 2008; amended in R09-16/R10-4 at 34 Ill. Reg. 18535, effective November 12, 2010; amended in R11-2/R11-16 at 35 Ill. Reg. 17672, effective October 14, 2011; amended in R12-7 at 36 Ill. Reg. 8740, effective June 4, 2012; amended in R13-5 at 37 Ill. Reg. 3180, effective March 4, 2013; amended in R13-15 at 37 Ill. Reg. 17726, effective October 24, 2013; amended in R14-13 at 38 Ill. Reg. _____, effective _____.

SUBPART B: DEFINITIONS AND REFERENCES

Section 720.110 Definitions

When used in 35 Ill. Adm. Code 720 through 728, 733, 738, and 739 only, the following terms have the meanings given below:

"Aboveground tank" means a device meeting the definition of tank that is situated in such a way that the entire surface area of the tank is completely above the plane of the adjacent surrounding surface and the entire surface area of the tank (including the tank bottom) is able to be visually inspected.

"Active life" of a facility means the period from the initial receipt of hazardous waste at the facility until the Agency receives certification of final closure.

"Active portion" means that portion of a facility where treatment, storage, or disposal operations are being or have been conducted after May 19, 1980, and which is not a closed portion. (See also "closed portion" and "inactive portion.")

"Administrator" means the Administrator of the United States Environmental Protection Agency or the Administrator's designee.

"Agency" means the Illinois Environmental Protection Agency.

"Ancillary equipment" means any device, including, but not limited to, such devices as piping, fittings, flanges, valves, and pumps, that is used to distribute, meter, or control the flow of hazardous waste from its point of generation to storage or treatment tanks, between hazardous waste storage and treatment tanks to a point of disposal onsite, or to a point of shipment for disposal off-site.

"Aquifer" means a geologic formation, group of formations, or part of a formation capable of yielding a significant amount of groundwater to wells or springs.

"Authorized representative" means the person responsible for the overall operation of a facility or an operational unit (i.e., part of a facility), e.g., the plant manager, superintendent, or person of equivalent responsibility.

"Battery" means a device that consists of one or more electrically connected electrochemical cells that is designed to receive, store, and deliver electric energy. An electrochemical cell is a system consisting of an anode, cathode, and an electrolyte, plus such connections (electrical and mechanical) as may be needed to allow the cell to deliver or receive electrical energy. The term battery also includes an intact, unbroken battery from which the electrolyte has been removed.

"Board" means the Illinois Pollution Control Board:~~.~~

"Boiler" by means an enclosed device using controlled flame combustion and having the following characteristics:

Boiler by physical characteristics.

The unit must have physical provisions for recovering and exporting thermal energy in the form of steam, heated fluids, or heated gases; and the unit's combustion chamber and primary energy recovery sections must be of integral design. To be of integral design, the combustion chamber and the primary energy recovery sections (such as waterwalls and superheaters) must be physically formed into one manufactured or assembled unit. A unit in which the combustion chamber and the primary energy recovery sections are joined only by ducts or connections carrying flue gas is not integrally designed; however, secondary energy recovery equipment (such as economizers or air preheaters) need not be physically formed into the same unit as the combustion chamber and the primary energy recovery section. The following units are not precluded from being boilers solely because they are not of integral design: process heaters (units that transfer energy directly to a process stream) and fluidized bed combustion units; and

While in operation, the unit must maintain a thermal energy recovery efficiency of at least 60 percent, calculated in terms of the recovered energy compared with the thermal value of the fuel; and

The unit must export and utilize at least 75 percent of the recovered energy, calculated on an annual basis. In this calculation, no credit may be given for recovered heat used internally in the same unit. (Examples of internal use are the preheating of fuel or combustion air, and the driving of induced or forced draft fans or feedwater pumps.); or

Boiler by designation. The unit is one that the Board has determined, on a case-by-case basis, to be a boiler, after considering the standards in Section 720.132.

"Carbon dioxide stream" means carbon dioxide that has been captured from an emission source (e.g., a power plant), plus incidental associated substances derived from the source materials and the capture process, and any substances added to the stream to enable or improve the injection process.

"Carbon regeneration unit" means any enclosed thermal treatment device used to regenerate spent activated carbon.

"Cathode ray tube" or "CRT" means a vacuum tube, composed primarily of glass, which is the visual or video display component of an electronic device. A "used, intact CRT" means a CRT whose vacuum has not been released. A "used, broken CRT" means glass removed from its housing or casing whose vacuum has been released.

"Certification" means a statement of professional opinion based upon knowledge and belief.

"Closed portion" means that portion of a facility that an owner or operator has closed in accordance with the approved facility closure plan and all applicable closure requirements. (See also "active portion" and "inactive portion.")

"Component" means either the tank or ancillary equipment of a tank system.

"Confined aquifer" means an aquifer bounded above and below by impermeable beds or by beds of distinctly lower permeability than that of the aquifer itself; an aquifer containing confined groundwater.

"Container" means any portable device in which a material is stored, transported,

treated, disposed of, or otherwise handled.

"Containment building" means a hazardous waste management unit that is used to store or treat hazardous waste pursuant to the provisions of Subpart DD of 35 Ill. Adm. Code 724 and Subpart DD of 35 Ill. Adm. Code 725.

"Contingency plan" means a document setting out an organized, planned and coordinated course of action to be followed in case of a fire, explosion, or release of hazardous waste or hazardous waste constituents that could threaten human health or the environment.

"Corrosion expert" means a person who, by reason of knowledge of the physical sciences and the principles of engineering and mathematics, acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person must be certified as being qualified by the National Association of Corrosion Engineers (NACE) or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control on buried or submerged metal piping systems and metal tanks.

"CRT collector" means a person who receives used, intact CRTs for recycling, repair, resale, or donation.

"CRT glass manufacturer" means an operation or part of an operation that uses a furnace to manufacture CRT glass.

"CRT processing" means conducting all of the following activities:

Receiving broken or intact CRTs;

Intentionally breaking intact CRTs or further breaking or separating broken CRTs; and

Sorting or otherwise managing glass removed from CRT monitors.

"Designated facility" means either of the following entities:

A hazardous waste treatment, storage, or disposal facility that has been designated on the manifest by the generator, pursuant to 35 Ill. Adm. Code

722.120, of which any of the following is true:

The facility has received a RCRA permit (or interim status) pursuant to 35 Ill. Adm. Code 702, 703, and 705;

The facility has received a RCRA permit from USEPA pursuant to 40 CFR 124 and 270 ~~(2010~~);

The facility has received a RCRA permit from a state authorized by USEPA pursuant to 40 CFR 271 ~~(2010)~~; or

The facility is regulated pursuant to 35 Ill. Adm. Code 721.106(c)(2) or Subpart F of 35 Ill. Adm. Code 266; or

A generator site designated by the hazardous waste generator on the manifest to receive back its own waste as a return shipment from a designated hazardous waste treatment, storage, or disposal facility that has rejected the waste in accordance with 35 Ill. Adm. Code 724.172(f) or 725.172(f).

If a waste is destined to a facility in a state other than Illinois that has been authorized by USEPA pursuant to 40 CFR 271, but which has not yet obtained authorization to regulate that waste as hazardous, then the designated facility must be a facility allowed by the receiving state to accept such waste.

"Destination facility" means a facility that treats, disposes of, or recycles a particular category of universal waste, except those management activities described in 35 Ill. Adm. Code 733.113(a) and (c) and 733.133(a) and (c). A facility at which a particular category of universal waste is only accumulated is not a destination facility for the purposes of managing that category of universal waste.

"Dike" means an embankment or ridge of either natural or manmade materials used to prevent the movement of liquids, sludges, solids, or other materials.

"Dioxins and furans" ~~or "D/F"~~ means tetra, penta- , hexa- , hepta- , and octa-chlorinated dibenzo dioxins and furans.

"Director" means the Director of the Illinois Environmental Protection Agency.

"Discharge" or "hazardous waste discharge" means the accidental or intentional spilling, leaking, pumping, pouring, emitting, emptying, or dumping of hazardous waste into or on any land or water.

"Disposal" means the discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste or hazardous waste into or on any land or water so that such solid waste or hazardous waste or any constituent thereof may enter the environment or be emitted into the air or discharged into any waters, including groundwaters.

"Disposal facility" means a facility or part of a facility at which hazardous waste is intentionally placed into or on any land or water and at which waste will remain after closure. The term disposal facility does not include a corrective action management unit (CAMU) into which remediation wastes are placed.

"Drip pad" means an engineered structure consisting of a curbed, free-draining base, constructed of non-earthen materials and designed to convey preservative kick-back or drippage from treated wood, precipitation and surface water runon to an associated collection system at wood preserving plants.

"Elementary neutralization unit" means a device of which the following is true:

> It is used for neutralizing wastes that are hazardous only because they exhibit the corrosivity characteristic defined in 35 Ill. Adm. Code 721.122 or which are listed in Subpart D of 35 Ill. Adm. Code 721 only for this reason; and
>
> It meets the definition of tank, tank system, container, transport vehicle, or vessel in this Section.

"EPA hazardous waste number" or "USEPA hazardous waste number" means the number assigned by USEPA to each hazardous waste listed in Subpart D of 35 Ill. Adm. Code 721 and to each characteristic identified in Subpart C of 35 Ill. Adm. Code 721.

"EPA identification number" or "USEPA identification number" means the number assigned by USEPA pursuant to 35 Ill. Adm. Code 722 through 725 to each generator; transporter; and treatment, storage, or disposal facility.

"EPA region" or "USEPA region" means the states and territories found in any

one of the following ten regions:

Region I: Maine, Vermont, New Hampshire, Massachusetts, Connecticut, and Rhode Island.

Region II: New York, New Jersey, Commonwealth of Puerto Rico, and the U.S. Virgin Islands.

Region III: Pennsylvania, Delaware, Maryland, West Virginia, Virginia, and the District of Columbia.

Region IV: Kentucky, Tennessee, North Carolina, Mississippi, Alabama, Georgia, South Carolina, and Florida.

Region V: Minnesota, Wisconsin, Illinois, Michigan, Indiana, and Ohio.

Region VI: New Mexico, Oklahoma, Arkansas, Louisiana, and Texas.

Region VII: Nebraska, Kansas, Missouri, and Iowa.

Region VIII: Montana, Wyoming, North Dakota, South Dakota, Utah, and Colorado.

Region IX: California, Nevada, Arizona, Hawaii, Guam, American Samoa, and Commonwealth of the Northern Mariana Islands.

Region X: Washington, Oregon, Idaho, and Alaska.

"Equivalent method" means any testing or analytical method approved by the Board pursuant to Section 720.120.

"Existing hazardous waste management (HWM) facility" or "existing facility" means a facility that was in operation or for which construction commenced on or before November 19, 1980. A facility had commenced construction if the owner or operator had obtained the federal, State, and local approvals or permits necessary to begin physical construction and either of the following had occurred:

A continuous on-site, physical construction program had begun; or

The owner or operator had entered into contractual obligations that could

not be canceled or modified without substantial loss for physical construction of the facility to be completed within a reasonable time.

"Existing portion" means that land surface area of an existing waste management unit, included in the original Part A permit application, on which wastes have been placed prior to the issuance of a permit.

"Existing tank system" or "existing component" means a tank system or component that is used for the storage or treatment of hazardous waste and which was in operation, or for which installation was commenced, on or prior to July 14, 1986. Installation will be considered to have commenced if the owner or operator has obtained all federal, State, and local approvals or permits necessary to begin physical construction of the site or installation of the tank system and if either of the following is true:

A continuous on-site physical construction or installation program has begun; or

The owner or operator has entered into contractual obligations that cannot be canceled or modified without substantial loss for physical construction of the site or installation of the tank system to be completed within a reasonable time.

"Explosives or munitions emergency" means a situation involving the suspected or detected presence of unexploded ordnance (UXO), damaged or deteriorated explosives or munitions, an improvised explosive device (IED), other potentially explosive material or device, or other potentially harmful military chemical munitions or device, that creates an actual or potential imminent threat to human health, including safety, or the environment, including property, as determined by an explosives or munitions emergency response specialist. Such situations may require immediate and expeditious action by an explosives or munitions emergency response specialist to control, mitigate, or eliminate the threat.

"Explosives or munitions emergency response" means all immediate response activities by an explosives and munitions emergency response specialist to control, mitigate, or eliminate the actual or potential threat encountered during an explosives or munitions emergency. An explosives or munitions emergency response may include in-place render-safe procedures, treatment, or destruction of the explosives or munitions or transporting those items to another location to be rendered safe, treated, or destroyed. Any reasonable delay in the completion of an

explosives or munitions emergency response caused by a necessary, unforeseen, or uncontrollable circumstance will not terminate the explosives or munitions emergency. Explosives and munitions emergency responses can occur on either public or private lands and are not limited to responses at RCRA facilities.

"Explosives or munitions emergency response specialist" means an individual trained in chemical or conventional munitions or explosives handling, transportation, render-safe procedures, or destruction techniques. Explosives or munitions emergency response specialists include United States Department of Defense (USDOD) emergency explosive ordnance disposal (EOD), technical escort unit (TEU), and USDOD-certified civilian or contractor personnel and other federal, State, or local government or civilian personnel who are similarly trained in explosives or munitions emergency responses.

"Facility" means the following:

> All contiguous land and structures, other appurtenances, and improvements on the land used for treating, storing, or disposing of hazardous waste or for managing hazardous secondary materials prior to reclamation. A facility may consist of several treatment, storage, or disposal operational units (e.g., one or more landfills, surface impoundments, or combinations of them).
>
> For the purpose of implementing corrective action pursuant to 35 Ill. Adm. Code 724.201 or 35 Ill. Adm. Code 727.201, all contiguous property under the control of the owner or operator seeking a permit under Subtitle C of RCRA. This definition also applies to facilities implementing corrective action pursuant to RCRA section 3008(h).
>
> Notwithstanding the immediately-preceding paragraph of this definition, a remediation waste management site is not a facility that is subject to 35 Ill. Adm. Code 724.201, but a facility that is subject to corrective action requirements if the site is located within such a facility.

"Federal agency" means any department, agency, or other instrumentality of the federal government, any independent agency or establishment of the federal government, including any government corporation and the Government Printing Office.

"Federal, State, and local approvals or permits necessary to begin physical

construction" means permits and approvals required under federal, State, or local hazardous waste control statutes, regulations, or ordinances.

"Final closure" means the closure of all hazardous waste management units at the facility in accordance with all applicable closure requirements so that hazardous waste management activities pursuant to 35 Ill. Adm. Code 724 and 725 are no longer conducted at the facility unless subject to the provisions of 35 Ill. Adm. Code 722.134.

"Food-chain crops" means tobacco, crops grown for human consumption, and crops grown for feed for animals whose products are consumed by humans.

"Freeboard" means the vertical distance between the top of a tank or surface impoundment dike and the surface of the waste contained therein.

"Free liquids" means liquids that readily separate from the solid portion of a waste under ambient temperature and pressure.

"Gasification" means, for the purpose of complying with 35 Ill. Adm. Code 721.104(a)(12)(A), a process conducted in an enclosed device or system that is designed and operated to process petroleum feedstock, including oil-bearing hazardous secondary materials, through a series of highly controlled steps utilizing thermal decomposition, limited oxidation, and gas cleaning to yield a synthesis gas composed primarily of hydrogen and carbon monoxide gas.

"Generator" means any person, by site, whose act or process produces hazardous waste identified or listed in 35 Ill. Adm. Code 721 or whose act first causes a hazardous waste to become subject to regulation.

"Groundwater" means water below the land surface in a zone of saturation.

"Hazardous secondary material" means a secondary material (e.g., spent material, by-product, or sludge) that, when discarded, would be identified as hazardous waste pursuant to 35 Ill. Adm. Code 721.

"Hazardous secondary material generated and reclaimed under the control of the generator" means one of the following materials:

A material that is both generated and reclaimed at the generating facility (for purposes of this definition, generating facility means all contiguous

property owned, leased, or otherwise controlled by the hazardous secondary material generator);

A material that is generated and reclaimed at different facilities, if both of the following conditions are fulfilled:

Either the reclaiming facility is controlled by the generator, or both the generating facility and the reclaiming facility are controlled by the same person, as "person" is defined in this Section; and

The generator provides either of the following certifications:

"On behalf of [insert generator facility name], I certify that this facility will send the indicated hazardous secondary material to [insert reclaimer facility name], which is controlled by [insert generator facility name] and that [insert the name of either facility] has acknowledged full responsibility for the safe management of the hazardous secondary material."

or

"On behalf of [insert generator facility name] I certify that this facility will send the indicated hazardous secondary material to [insert reclaimer facility name], that both facilities are under common control, and that [insert name of either facility] has acknowledged full responsibility for the safe management of the hazardous secondary material."

For purposes of this definition, "control" means the power to direct the policies of the facility, whether by the ownership of stock, voting rights, or otherwise, except that contractors who operate facilities on behalf of a different person, as "person" is defined in this Section, shall not be deemed to "control" such facilities; or

A material that is generated pursuant to a written contract between a tolling contractor and a toll manufacturer and which is reclaimed by the tolling contractor, if the tolling contractor certifies the following:

"On behalf of [insert tolling contractor name], I certify that [insert tolling contractor name], has a written contract with [insert toll manufacturer name] to manufacture [insert name of product or intermediate] which is made from specified unused materials, and that [insert tolling contractor name] will reclaim the hazardous secondary materials generated during this manufacture. On behalf of [insert tolling contractor name], I also certify that [insert tolling contractor name] retains ownership of, and responsibility for, the hazardous secondary materials that are generated during the course of the manufacture, including any releases of hazardous secondary materials that occur during the manufacturing process."

For purposes of this definition, "tolling contractor" means a person who arranges for the production of a product or intermediate made from specified unused materials through a written contract with a toll manufacturer. "Toll manufacturer" means a person who produces a product or intermediate made from specified unused materials pursuant to a written contract with a tolling contractor.

"Hazardous secondary material generator" means any person whose act or process produces hazardous secondary materials at the generating facility. For purposes of this definition, "generating facility" means all contiguous property owned, leased, or otherwise controlled by the hazardous secondary material generator. For the purposes of Sections 721.102(a)(2)(B) and 721.104(a)(23), a facility that collects hazardous secondary materials from other persons is not the hazardous secondary material generator.

"Hazardous waste" means a hazardous waste as defined in 35 Ill. Adm. Code 721.103.

"Hazardous waste constituent" means a constituent that caused the hazardous waste to be listed in Subpart D of 35 Ill. Adm. Code 721, or a constituent listed in 35 Ill. Adm. Code 721.124.

"Hazardous waste management unit" is a contiguous area of land on or in which hazardous waste is placed, or the largest area in which there is significant likelihood of mixing hazardous waste constituents in the same area. Examples of hazardous waste management units include a surface impoundment, a waste pile, a land treatment area, a landfill cell, an incinerator, a tank and its associated piping and underlying containment system, and a container storage area. A

container alone does not constitute a unit; the unit includes containers, and the land or pad upon which they are placed.

"Inactive portion" means that portion of a facility that was~~is~~ not operated after November 19, 1980. (See also "active portion" and "closed portion.")

"Incinerator" means any enclosed device of which the following is true:

The facility uses controlled flame combustion, and both of the following are true of the facility:

The facility does not meet the criteria for classification as a boiler, sludge dryer, or carbon regeneration unit, nor

The facility is not listed as an industrial furnace; or

The facility meets the definition of infrared incinerator or plasma arc incinerator.

"Incompatible waste" means a hazardous waste that is unsuitable for the following:

Placement in a particular device or facility because it may cause corrosion or decay of containment materials (e.g., container inner liners or tank walls); or

Commingling with another waste or material under uncontrolled conditions because the commingling might produce heat or pressure, fire, or explosion, violent reaction, toxic dusts, mists, fumes or gases, or flammable fumes or gases.

(See Appendix E to 35 Ill. Adm. Code 724 and Appendix E to 35 Ill. Adm. Code 725 for references that list examples.)

"Industrial furnace" means any of the following enclosed devices that are integral components of manufacturing processes and that use thermal treatment to accomplish recovery of materials or energy:

Cement kilns;

Lime kilns;

Aggregate kilns;

Phosphate kilns;

Coke ovens;

Blast furnaces;

Smelting, melting, and refining furnaces (including pyrometallurgical devices such as cupolas, reverberator furnaces, sintering machines, roasters, and foundry furnaces);

Titanium dioxide chloride process oxidation reactors;

Methane reforming furnaces;

Pulping liquor recovery furnaces;

Combustion devices used in the recovery of sulfur values from spent sulfuric acid;

Halogen acid furnaces (HAFs) for the production of acid from halogenated hazardous waste generated by chemical production facilities where the furnace is located on the site of a chemical production facility, the acid product has a halogen acid content of at least three percent, the acid product is used in a manufacturing process, and, except for hazardous waste burned as fuel, hazardous waste fed to the furnace has a minimum halogen content of 20 percent, as generated; and

Any other such device as the Agency determines to be an industrial furnace on the basis of one or more of the following factors:

The design and use of the device primarily to accomplish recovery of material products;

The use of the device to burn or reduce raw materials to make a material product;

The use of the device to burn or reduce secondary materials as effective substitutes for raw materials, in processes using raw materials as principal feedstocks;

The use of the device to burn or reduce secondary materials as ingredients in an industrial process to make a material product;

The use of the device in common industrial practice to produce a material product; and

Other relevant factors.

"Individual generation site" means the contiguous site at or on which one or more hazardous wastes are generated. An individual generation site, such as a large manufacturing plant, may have one or more sources of hazardous waste but is considered a single or individual generation site if the site or property is contiguous.

"Infrared incinerator" means any enclosed device that uses electric powered resistance heaters as a source of radiant heat followed by an afterburner using controlled flame combustion and which is not listed as an industrial furnace.

"Inground tank" means a device meeting the definition of tank whereby a portion of the tank wall is situated to any degree within the ground, thereby preventing visual inspection of that external surface area of the tank that is in the ground.

"In operation" refers to a facility that is treating, storing, or disposing of hazardous waste.

"Injection well" means a well into which fluids are being injected. (See also "underground injection.")

"Inner liner" means a continuous layer of material placed inside a tank or container that protects the construction materials of the tank or container from the contained waste or reagents used to treat the waste.

"Installation inspector" means a person who, by reason of knowledge of the physical sciences and the principles of engineering, acquired by a professional education and related practical experience, is qualified to supervise the installation of tank systems.

"Intermediate facility" means any facility that stores hazardous secondary materials for more than 10 days and which is neither a hazardous secondary material generator nor a reclaimer of hazardous secondary material.

"International shipment" means the transportation of hazardous waste into or out of the jurisdiction of the United States.

"Lamp" or "universal waste lamp" means the bulb or tube portion of an electric lighting device. A lamp is specifically designed to produce radiant energy, most often in the ultraviolet, visible, or infrared regions of the electromagnetic spectrum. Examples of common universal waste lamps include, but are not limited to, fluorescent, high intensity discharge, neon, mercury vapor, high-pressure sodium, and metal halide lamps.

"Land-based unit" means an area where hazardous secondary materials are placed in or on the land before recycling. This definition does not include land-based production units.

"Land treatment facility" means a facility or part of a facility at which hazardous waste is applied onto or incorporated into the soil surface; such facilities are disposal facilities if the waste will remain after closure.

"Landfill" means a disposal facility or part of a facility where hazardous waste is placed in or on land and which is not a pile, a land treatment facility, a surface impoundment, an underground injection well, a salt dome formation, a salt bed formation, an underground mine, a cave, or a corrective action management unit (CAMU).

"Landfill cell" means a discrete volume of a hazardous waste landfill that uses a liner to provide isolation of wastes from adjacent cells or wastes. Examples of landfill cells are trenches and pits.

"LDS" means leak detection system.

"Leachate" means any liquid, including any suspended components in the liquid, that has percolated through or drained from hazardous waste.

"Liner" means a continuous layer of natural or manmade materials beneath or on the sides of a surface impoundment, landfill, or landfill cell that restricts the

downward or lateral escape of hazardous waste, hazardous waste constituents, or leachate.

"Leak-detection system" means a system capable of detecting the failure of either the primary or secondary containment structure or the presence of a release of hazardous waste or accumulated liquid in the secondary containment structure. Such a system must employ operational controls (e.g., daily visual inspections for releases into the secondary containment system of aboveground tanks) or consist of an interstitial monitoring device designed to detect continuously and automatically the failure of the primary or secondary containment structure or the presence of a release of hazardous waste into the secondary containment structure.

"Management" or "hazardous waste management" means the systematic control of the collection, source separation, storage, transportation, processing, treatment, recovery, and disposal of hazardous waste.

"Manifest" means the shipping document USEPA Form 8700-22 (including, if necessary, USEPA Form 8700-22A) originated and signed by the generator or offeror that contains the information required by Subpart B of 35 Ill. Adm. Code 722 and the applicable requirements of 35 Ill. Adm. Code 722 through 727.

"Manifest tracking number" means the alphanumeric identification number (i.e., a unique three letter suffix preceded by nine numerical digits) that is pre-printed in Item 4 of the manifest by a registered source.

"Mercury-containing equipment" means a device or part of a device (including thermostats, but excluding batteries and lamps) that contains elemental mercury integral to its function.

"Military munitions" means all ammunition products and components produced or used by or for the United States Department of Defense or the United States Armed Services for national defense and security, including military munitions under the control of the United States Department of Defense (USDOD), the United States Coast Guard, the United States Department of Energy (USDOE), and National Guard personnel. The term military munitions includes: confined gaseous, liquid, and solid propellants, explosives, pyrotechnics, chemical and riot control agents, smokes, and incendiaries used by USDOD components, including bulk explosives and chemical warfare agents, chemical munitions, rockets, guided and ballistic missiles, bombs, warheads, mortar rounds, artillery ammunition, small arms ammunition, grenades, mines, torpedoes, depth charges, cluster

munitions and dispensers, demolition charges, and devices and components of these items and devices. Military munitions do not include wholly inert items, improvised explosive devices, and nuclear weapons, nuclear devices, and nuclear components of these items and devices. However, the term does include non-nuclear components of nuclear devices, managed under USDOE's nuclear weapons program after all sanitization operations required under the Atomic Energy Act of 1954 (42 USC 2014 et seq.), as amended, have been completed.

"Mining overburden returned to the mine site" means any material overlying an economic mineral deposit that is removed to gain access to that deposit and is then used for reclamation of a surface mine.

"Miscellaneous unit" means a hazardous waste management unit where hazardous waste is treated, stored, or disposed of and that is not a container; tank; surface impoundment; pile; land treatment unit; landfill; incinerator; boiler; industrial furnace; underground injection well with appropriate technical standards pursuant to 35 Ill. Adm. Code 730; containment building; corrective action management unit (CAMU); unit eligible for a research, development, and demonstration permit pursuant to 35 Ill. Adm. Code 703.231; or staging pile.

"Movement" means hazardous waste that is transported to a facility in an individual vehicle.

"NAICS Code" means the code number assigned a facility using the "North American Industry Classification System," incorporated by reference in Section 720.111.

"New hazardous waste management facility" or "new facility" means a facility that began operation, or for which construction commenced after November 19, 1980. (See also "Existing hazardous waste management facility.")

"New tank system" or "new tank component" means a tank system or component that will be used for the storage or treatment of hazardous waste and for which installation commenced after July 14, 1986; except, however, for purposes of 35 Ill. Adm. Code 724.293(g)(2) and 725.293(g)(2), a new tank system is one for which construction commenced after July 14, 1986. (See also "existing tank system.")

"No free liquids", as used in 35 Ill. Adm. Code 721.104(a)(26) and (b)(18), means that solvent-contaminated wipes may not contain free liquids, as

determined by Method 9095B (Paint Filter Liquids Test), included in "Test Methods for Evaluating Solid Waste, Physical/Chemical Methods", incorporated by reference in Section 720.111, and that there is no free liquid in the container holding the wipes. No free liquids may also be determined using another standard or test method that the Agency has determined by permit condition is equivalent to Method 9095B.

"Onground tank" means a device meeting the definition of tank that is situated in such a way that the bottom of the tank is on the same level as the adjacent surrounding surfaces so that the external tank bottom cannot be visually inspected.

"On-site" means the same or geographically contiguous property that may be divided by public or private right-of-way, provided the entrance and exit between the properties is at a crossroads intersection and access is by crossing as opposed to going along the right-of-way. Non-contiguous~~Noncontiguous~~ properties owned by the same person but connected by a right-of-way that the owner controls and to which the public does not have access is also considered on-site property.

"Open burning" means the combustion of any material without the following characteristics:

Control of combustion air to maintain adequate temperature for efficient combustion;

Containment of the combustion reaction in an enclosed device to provide sufficient residence time and mixing for complete combustion; and

Control of emission of the gaseous combustion products.

(See also "incineration" and "thermal treatment.")

"Operator" means the person responsible for the overall operation of a facility.

"Owner" means the person that owns a facility or part of a facility.

"Partial closure" means the closure of a hazardous waste management unit in accordance with the applicable closure requirements of 35 Ill. Adm. Code 724 or 725 at a facility that contains other active hazardous waste management units.

For example, partial closure may include the closure of a tank (including its associated piping and underlying containment systems), landfill cell, surface impoundment, waste pile, or other hazardous waste management unit, while other units of the same facility continue to operate.

"Person" means an individual, trust, firm, joint stock company, federal agency, corporation (including a government corporation), partnership, association, state, municipality, commission, political subdivision of a state, or any interstate body.

"Personnel" or "facility personnel" means all persons who work at or oversee the operations of a hazardous waste facility and whose actions or failure to act may result in noncompliance with 35 Ill. Adm. Code 724 or 725.

"Pesticide" means any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating any pest or intended for use as a plant regulator, defoliant, or desiccant, other than any article that fulfills one of the following descriptions:

It is a new animal drug under section 201(v) of the Federal Food, Drug and Cosmetic Act (FFDCA; 21 USC 321(v)), incorporated by reference in Section 720.111(c);

It is an animal drug that has been determined by regulation of the federal Secretary of Health and Human Services pursuant to FFDCA section 512 (21 USC 360b), incorporated by reference in Section 720.111(c), to be an exempted new animal drug; or

It is an animal feed under FFDCA section 201(w) (21 USC 321(w)), incorporated by reference in Section 720.111(c), that bears or contains any substances described in either of the two preceding paragraphs of this definition.
BOARD NOTE: The second exception of corresponding 40 CFR 260.10 reads as follows: "Is an animal drug that has been determined by regulation of the Secretary of Health and Human Services not to be a new animal drug." This is very similar to the language of section 2(u) of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA; 7 USC 136(u)). The three exceptions, taken together, appear intended not to include as pesticide any material within the scope of federal Food and Drug Administration regulation. The Board codified this provision with the intent of retaining the same meaning as its federal counterpart while

adding the definiteness required under Illinois law.

"Pile" means any non-containerized~~noncontainerized~~ accumulation of solid, non-flowing hazardous waste that is used for treatment or storage, and that is not a containment building.

"Plasma arc incinerator" means any enclosed device that uses a high intensity electrical discharge or arc as a source of heat followed by an afterburner using controlled flame combustion and which is not listed as an industrial furnace.

"Point source" means any discernible, confined, and discrete conveyance, including, but not limited to, any pipe, ditch, channel, tunnel, conduit, well, discrete fissure, container, rolling stock, concentrated animal feeding operation, or vessel or other floating craft from which pollutants are or may be discharged. This term does not include return flows from irrigated agriculture.

"Publicly owned treatment works" or "POTW" is as defined in 35 Ill. Adm. Code 310.110.

"Qualified groundwater scientist" means a scientist or engineer who has received a baccalaureate or postgraduate degree in the natural sciences or engineering, and has sufficient training and experience in groundwater hydrology and related fields, as demonstrated by state registration, professional certifications, or completion of accredited university courses that enable the individual to make sound professional judgments regarding groundwater monitoring and contaminant rate and transport.
BOARD NOTE: State registration includes, but is not limited to, registration as a professional engineer with the Department of Professional Regulation, pursuant to 225 ILCS 325 and 68 Ill. Adm. Code 1380. Professional certification includes, but is not limited to, certification under the certified groundwater professional program of the National Ground Water Association.

"RCRA" means the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended (42 USC 6901 et seq.).

"RCRA standardized permit" means a RCRA permit issued pursuant to Subpart J of 35 Ill. Adm. Code 703 and Subpart G of 35 Ill. Adm. Code 702 that authorizes management of hazardous waste. The RCRA standardized permit may have two parts: a uniform portion issued in all cases and a supplemental portion issued at the discretion of the Agency.

"Regional Administrator" means the Regional Administrator for the USEPA region in which the facility is located or the Regional Administrator's designee.

"Remediation waste" means all solid and hazardous wastes, and all media (including groundwater, surface water, soils, and sediments) and debris that are managed for implementing cleanup.

"Remediation waste management site" means a facility where an owner or operator is or will be treating, storing, or disposing of hazardous remediation wastes. A remediation waste management site is not a facility that is subject to corrective action pursuant to 35 Ill. Adm. Code 724.201, but a remediation waste management site is subject to corrective action requirements if the site is located in such a facility.

"Replacement unit" means a landfill, surface impoundment, or waste pile unit from which all or substantially all of the waste is removed, and which is subsequently reused to treat, store, or dispose of hazardous waste. Replacement unit does not include a unit from which waste is removed during closure, if the subsequent reuse solely involves the disposal of waste from that unit and other closing units or corrective action areas at the facility, in accordance with a closure or corrective action plan approved by USEPA or the Agency.

"Representative sample" means a sample of a universe or whole (e.g., waste pile, lagoon, groundwater) that can be expected to exhibit the average properties of the universe or whole.

"Runoff" means any rainwater, leachate, or other liquid that drains over land from any part of a facility.

"Runon" means any rainwater, leachate, or other liquid that drains over land onto any part of a facility.

"Saturated zone" or "zone of saturation" means that part of the earth's crust in which all voids are filled with water.

"SIC code" means "Standard Industrial Classification code," as assigned to a site by the United States Department of Transportation, Federal Highway Administration, based on the particular activities that occur on the site, as set forth in its publication "Standard Industrial Classification Manual," incorporated by

reference in Section 720.111(a).

"Sludge" means any solid, semi-solid, or liquid waste generated from a municipal, commercial, or industrial wastewater treatment plant, water supply treatment plant, or air pollution control facility, exclusive of the treated effluent from a wastewater treatment plant.

"Sludge dryer" means any enclosed thermal treatment device that is used to dehydrate sludge and which has a total thermal input, excluding the heating value of the sludge itself, of 2,500 Btu/lb or less of sludge treated on a wet-weight basis.

"Small quantity generator" means a generator that generates less than 1,000 kg of hazardous waste in a calendar month.

"Solid waste" means a solid waste as defined in 35 Ill. Adm. Code 721.102.

"Solvent-contaminated wipe" means a wipe that, after use or after cleaning up a spill, fulfills one or more of the following conditions:

The wipe contains one or more of the F001 through F005 solvents listed in 35 Ill. Adm. Code 721.131 or the corresponding P- or U-listed solvents found in 35 Ill. Adm. Code 721.133;

The wipe exhibits a hazardous characteristic found in Subpart C of 35 Ill. Adm. Code 721 when that characteristic results from a solvent listed in 35 Ill. Adm. Code 721; or

The wipe exhibits only the hazardous waste characteristic of ignitability found in 35 Ill. Adm. Code 721.121 due to the presence of one or more solvents that are not listed in 35 Ill. Adm. Code 721.

Solvent-contaminated wipes that contain listed hazardous waste other than solvents, or exhibit the characteristic of toxicity, corrosivity, or reactivity due to contaminants other than solvents, are not eligible for the exclusions at 35 Ill. Adm. Code 721.104(a)(26) and (b)(18).

"Sorbent" means a material that is used to soak up free liquids by either adsorption or absorption, or both. "Sorb" means to either adsorb or absorb, or both.

"Staging pile" means an accumulation of solid, non-flowing "remediation waste" (as defined in this Section) that is not a containment building and that is used only during remedial operations for temporary storage at a facility. Staging piles must be designated by the Agency according to 35 Ill. Adm. Code 724.654.

"State" means any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Storage" means the holding of hazardous waste for a temporary period, at the end of which the hazardous waste is treated, disposed of, or stored elsewhere.

"Sump" means any pit or reservoir that meets the definition of tank and those troughs or trenches connected to it that serve to collect hazardous waste for transport to hazardous waste storage, treatment, or disposal facilities; except that, as used in the landfill, surface impoundment, and waste pile rules, sump means any lined pit or reservoir that serves to collect liquids drained from a leachate collection and removal system or leak detection system for subsequent removal from the system.

"Surface impoundment" or "impoundment" means a facility or part of a facility that is a natural topographic depression, manmade excavation, or diked area formed primarily of earthen materials (although it may be lined with manmade materials) that is designed to hold an accumulation of liquid wastes or wastes containing free liquids and which is not an injection well. Examples of surface impoundments are holding, storage, settling and aeration pits, ponds, and lagoons.

"Tank" means a stationary device, designed to contain an accumulation of hazardous waste that is constructed primarily of non-earthen~~nonearthen~~ materials (e.g., wood, concrete, steel, plastic) that provide structural support.

"Tank system" means a hazardous waste storage or treatment tank and its associated ancillary equipment and containment system.

"TEQ" means toxicity equivalence, the international method of relating the toxicity of various dioxin and furan congeners to the toxicity of 2,3,7,8-tetra-chlorodibenzo-p-dioxin.

"Thermal treatment" means the treatment of hazardous waste in a device that uses elevated temperatures as the primary means to change the chemical, physical, or

biological character or composition of the hazardous waste. Examples of thermal treatment processes are incineration, molten salt, pyrolysis, calcination, wet air oxidation, and microwave discharge. (See also "incinerator" and "open burning.")

"Thermostat" means a temperature control device that contains metallic mercury in an ampule attached to a bimetal sensing element and mercury-containing ampules that have been removed from such a temperature control device in compliance with 35 Ill. Adm. Code 733.113(c)(2) or 733.133(c)(2).

"Totally enclosed treatment facility" means a facility for the treatment of hazardous waste that is directly connected to an industrial production process and which is constructed and operated in a manner that prevents the release of any hazardous waste or any constituent thereof into the environment during treatment. An example is a pipe in which waste acid is neutralized.

"Transfer facility" means any transportation-related facility, including loading docks, parking areas, storage areas, and other similar areas where shipments of hazardous waste or hazardous secondary materials are held during the normal course of transportation.

"Transport vehicle" means a motor vehicle or rail car used for the transportation of cargo by any mode. Each cargo-carrying body (trailer, railroad freight car, etc.) is a separate transport vehicle.

"Transportation" means the movement of hazardous waste by air, rail, highway, or water.

"Transporter" means a person engaged in the off-site transportation of hazardous waste by air, rail, highway, or water.

"Treatability study" means the following:

A study in which a hazardous waste is subjected to a treatment process to determine the following:

Whether the waste is amenable to the treatment process;

What pretreatment (if any) is required;

The optimal process conditions needed to achieve the desired

treatment;

The efficiency of a treatment process for a specific waste or wastes; and

The characteristics and volumes of residuals from a particular treatment process;

Also included in this definition for the purpose of 35 Ill. Adm. Code 721.104(e) and (f) exemptions are liner compatibility, corrosion and other material compatibility studies, and toxicological and health effects studies. A treatability study is not a means to commercially treat or dispose of hazardous waste.

"Treatment" means any method, technique, or process, including neutralization, designed to change the physical, chemical, or biological character or composition of any hazardous waste so as to neutralize the waste, recover energy or material resources from the waste, or render the waste non-hazardous or less hazardous; safer to transport, store, or dispose of; or amenable for recovery, amenable for storage, or reduced in volume.

"Treatment zone" means a soil area of the unsaturated zone of a land treatment unit within which hazardous constituents are degraded, transformed, or immobilized.

"Underground injection" means the subsurface emplacement of fluids through a bored, drilled, or driven well or through a dug well, where the depth of the dug well is greater than the largest surface dimension. (See also "injection well.")

"Underground tank" means a device meeting the definition of tank whose entire surface area is totally below the surface of and covered by the ground.

"Unfit-for-use tank system" means a tank system that has been determined, through an integrity assessment or other inspection, to be no longer capable of storing or treating hazardous waste without posing a threat of release of hazardous waste to the environment.

"United States" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Universal waste" means any of the following hazardous wastes that are managed pursuant to the universal waste requirements of 35 Ill. Adm. Code 733:

Batteries, as described in 35 Ill. Adm. Code 733.102;

Pesticides, as described in 35 Ill. Adm. Code 733.103;

Mercury-containing equipment, as described in 35 Ill. Adm. Code 733.104; and

Lamps, as described in 35 Ill. Adm. Code 733.105.

"Universal waste handler" means either of the following:

A generator (as defined in this Section) of universal waste; or

The owner or operator of a facility, including all contiguous property, that receives universal waste from other universal waste handlers, accumulates the universal waste, and sends that universal waste to another universal waste handler, to a destination facility, or to a foreign destination.

"Universal waste handler" does not mean either of the following:

A person that treats (except under the provisions of Section 733.113(a) or (c) or 733.133(a) or (c)), disposes of, or recycles universal waste; or

A person engaged in the off-site transportation of universal waste by air, rail, highway, or water, including a universal waste transfer facility.

"Universal waste transporter" means a person engaged in the off-site transportation of universal waste by air, rail, highway, or water.

"Unsaturated zone" or "zone of aeration" means the zone between the land surface and the water table.

"Uppermost aquifer" means the geologic formation nearest the natural ground surface that is an aquifer, as well as lower aquifers that are hydraulically

interconnected with this aquifer within the facility's property boundary.

"USDOT" or "Department of Transportation" means the United States Department of Transportation.

"Used oil" means any oil that has been refined from crude oil, or any synthetic oil, that has been used and as a result of such use is contaminated by physical or chemical impurities.

"USEPA" or "EPA" means the United States Environmental Protection Agency.

"USPS" means the United States Postal Service.

"Vessel" includes every description of watercraft used or capable of being used as a means of transportation on the water.

"Wastewater treatment unit" means a device of which the following is true:

It is part of a wastewater treatment facility that has an NPDES permit pursuant to 35 Ill. Adm. Code 309 or a pretreatment permit or authorization to discharge pursuant to 35 Ill. Adm. Code 310;

It receives and treats or stores an influent wastewater that is a hazardous waste as defined in 35 Ill. Adm. Code 721.103, or generates and accumulates a wastewater treatment sludge that is a hazardous waste as defined in 35 Ill. Adm. Code 721.103, or treats or stores a wastewater treatment sludge that is a hazardous waste as defined in 35 Ill. Adm. Code 721.103; and

It meets the definition of tank or tank system in this Section.

"Water (bulk shipment)" means the bulk transportation of hazardous waste that is loaded or carried on board a vessel without containers or labels.

"Well" means any shaft or pit dug or bored into the earth, generally of a cylindrical form, and often walled with bricks or tubing to prevent the earth from caving in.

"Well injection" (See "underground injection.")

"Wipe" means a woven or non-woven shop towel, rag, pad, or swab made of wood pulp, fabric, cotton, polyester blends, or other material.

"Zone of engineering control" means an area under the control of the owner or operator that, upon detection of a hazardous waste release, can be readily cleaned up prior to the release of hazardous waste or hazardous constituents to groundwater or surface water.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 720.111 References

The following documents are incorporated by reference for the purposes of this Part and 35 Ill. Adm. Code 702 through 705, 721 through 728, 730, 733, 738, and 739:

a) Non-Regulatory Government Publications and Publications of Recognized Organizations and Associations:

ACGME. Available from the Accreditation Council for Graduate Medical Education, 515 North State Street, Suite 2000, Chicago, IL 60654, 312-755-5000:

"Accreditation Council for Graduate Medical Education: Glossary of Terms," March 19, 2009, referenced in 35 Ill. Adm. Code 722.300.

BOARD NOTE: Also available on the Internet for download and viewing as a PDF file at the following Internet address: http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf.

ACI. Available from the American Concrete Institute, Box 19150, Redford Station, Detroit, Michigan 48219:

ACI 318-83: "Building Code Requirements for Reinforced Concrete," adopted November 1983, referenced in 35 Ill. Adm. Code 724.673 and 725.543.

ANSI. Available from the American National Standards Institute, 1430 Broadway, New York, New York 10018, 212-354-3300:

See ASME/ANSI B31.3 and B31.4 and supplements below in this subsection (a) under ASME.

API. Available from the American Petroleum Institute, 1220 L Street, N.W., Washington, D.C. 20005, 202-682-8000:

"Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems," API Recommended Practice 1632, Second Edition, December 1987, referenced in 35 Ill. Adm. Code 724.292, 724.295, 725.292, and 725.295.

"Evaporative Loss from External Floating-Roof Tanks," API publication 2517, Third Edition, February 1989, USEPA-approved for 35 Ill. Adm. Code 725.984.

"Guide for Inspection of Refinery Equipment," Chapter XIII, "Atmospheric and Low Pressure Storage Tanks," 4th Edition, 1981, reaffirmed December 1987, referenced in 35 Ill. Adm. Code 724.291, 724.293, 725.291, and 725.292.

"Installation of Underground Petroleum Storage Systems," API Recommended Practice 1615, Fourth Edition, November 1987, referenced in 35 Ill. Adm. Code 724.292.

ASME. Available from the American Society of Mechanical Engineers, 345 East 47th Street, New York, NY 10017, 212-705-7722:

"Chemical Plant and Petroleum Refinery Piping," ASME/ANSI B31.3-1987, as supplemented by B31.3a-1988 and B31.3b-1988, referenced in 35 Ill. Adm. Code 724.292 and 725.292. Also available from ANSI.

"Liquid Transportation Systems for Hydrocarbons, Liquid Petroleum Gas, Anhydrous Ammonia, and Alcohols," ASME/ANSI B31.4-1986, as supplemented by B31.4a-1987, referenced in 35 Ill. Adm. Code 724.292 and 725.292. Also available from ANSI.

ASTM. Available from American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959, 610-832-9585:

ASTM C 94-90, "Standard Specification for Ready-Mixed Concrete,"

approved March 30, 1990, referenced in 35 Ill. Adm. Code 724.673 and 725.543.

ASTM D 88-87, "Standard Test Method for Saybolt Viscosity," approved April 24, 1981, reapproved January 1987, referenced in 35 Ill. Adm. Code 726.200.

ASTM D 93-85, "Standard Test Methods for Flash Point by Pensky-Martens Closed Tester," approved October 25, 1985, USEPA-approved for 35 Ill. Adm. Code 721.121.

ASTM D 140-70, "Standard Practice for Sampling Bituminous Materials," approved 1970, referenced in Appendix A to 35 Ill. Adm. Code 721.

ASTM D 346-75, "Standard Practice for Collection and Preparation of Coke Samples for Laboratory Analysis," approved 1975, referenced in Appendix A to 35 Ill. Adm. Code 721.

ASTM D 420-69, "Guide to Site Characterization for Engineering, Design, and Construction Purposes," approved 1969, referenced in Appendix A to 35 Ill. Adm. Code 721.

ASTM D 1452-65, "Standard Practice for Soil Investigation and Sampling by Auger Borings," approved 1965, referenced in Appendix A to 35 Ill. Adm. Code 721.

ASTM D 1946-90, "Standard Practice for Analysis of Reformed Gas by Gas Chromatography," approved March 30, 1990, USEPA-approved for 35 Ill. Adm. Code 724.933 and 725.933.

ASTM D 2161-87, "Standard Practice for Conversion of Kinematic Viscosity to Saybolt Universal or to Saybolt Furol Viscosity," March 27, 1987, referenced in 35 Ill. Adm. Code 726.200.

ASTM D 2234-76, "Standard Practice for Collection of a Gross Sample of Coal," approved 1976, referenced in Appendix A to 35 Ill. Adm. Code 721.

ASTM D 2267-88, "Standard Test Method for Aromatics in Light Naphthas and Aviation Gasolines by Gas Chromatography," approved

November 17, 1988, USEPA-approved for 35 Ill. Adm. Code 724.963.

ASTM D 2382-88, "Standard Test Method for Heat of Combustion of Hydrocarbon Fuels by Bomb Calorimeter (High Precision Method)," approved October 31, 1988, USEPA-approved for 35 Ill. Adm. Code 724.933 and 725.933.

ASTM D 2879-92, "Standard Test Method for Vapor Pressure-Temperature Relationship and Initial Decomposition Temperature of Liquids by Isoteniscope," approved 1992, USEPA-approved for 35 Ill. Adm. Code 725.984, referenced in 35 Ill. Adm. Code 724.963 and 725.963.

ASTM D 3828-87, "Standard Test Methods for Flash Point of Liquids by Setaflash Closed Tester," approved December 14, 1988, USEPA-approved for 35 Ill. Adm. Code 721.121(a).

ASTM E 168-88, "Standard Practices for General Techniques of Infrared Quantitative Analysis," approved May 27, 1988, USEPA-approved for 35 Ill. Adm. Code 724.963.

ASTM E 169-87, "Standard Practices for General Techniques of Ultraviolet-Visible Quantitative Analysis," approved February 1, 1987, USEPA-approved for 35 Ill. Adm. Code 724.963.

ASTM E 260-85, "Standard Practice for Packed Column Gas Chromatography," approved June 28, 1985, USEPA-approved for 35 Ill. Adm. Code 724.963.

ASTM G 21-70 (1984a), "Standard Practice for Determining Resistance of Synthetic Polymer Materials to Fungi," referenced in 35 Ill. Adm. Code 724.414 and 725.414.

ASTM G 22-76 (1984b), "Standard Practice for Determining Resistance of Plastics to Bacteria," referenced in 35 Ill. Adm. Code 724.414 and 725.414.

GPO. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, 202-512-1800:

Standard Industrial Classification Manual (1972), and 1977 Supplement, republished in 1983, referenced in 35 Ill. Adm. Code 702.110 and Section 720.110.

"Test Methods for Evaluating Solid Waste, Physical/Chemical Methods," USEPA publication number EPA-530/SW-846 (Third Edition, November 1986), as amended by Updates I (July 1992), II (November 1994), IIA (August, 1993), IIB (January 1995), III (December 1996), IIIA (April 1998), and IIIB (November 2004) (document number 955-001-00000-1). See below in this subsection (a) under NTIS.

NACE. Available from the National Association of Corrosion Engineers, 1400 South Creek Dr., Houston, TX 77084, 713-492-0535:

"Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," NACE Recommended Practice RP0285-85, approved March 1985, referenced in 35 Ill. Adm. Code 724.292, 724.295, 725.292, and 725.295.

NFPA. Available from the National Fire Protection Association, 1 Batterymarch Park, Boston, MA 02269, 617-770-3000 or 800-344-3555:

"Flammable and Combustible Liquids Code," NFPA 30, issued July 18, 2003, as supplemented by TIA 03-1, issued July 15, 2004, and corrected by Errata 30-03-01, issued August 13, 2004, USEPA-approved for 35 Ill. Adm. Code 724.298, 725.298, and 727.290, referenced in 35 Ill. Adm. Code 725.301 and 726.211.

NTIS. Available from the U.S. Department of Commerce, National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161, 703-605-6000 or 800-553-6847 (Internet address: www.ntis.gov):

"APTI Course 415: Control of Gaseous Emissions," December 1981, USEPA publication number EPA-450/2-81-005, NTIS document number PB80-208895, USEPA-approved for 35 Ill. Adm. Code 703.210, 703.211, 703.352, 724.935, and 725.935.

BOARD NOTE: "APTI" denotes USEPA's "Air Pollution Training Institute" (Internet address: www.epa.gov/air/oaqps/eog/).

"Generic Quality Assurance Project Plan for Land Disposal Restrictions Program," USEPA publication number EPA-530/SW-87-011, March 15, 1987, NTIS document number PB88-170766, referenced in 35 Ill. Adm. Code 728.106.

"Method 1664, n-Hexane Extractable Material (HEM; Oil and Grease) and Silica Gel Treated n-Hexane Extractable Material (SGT-HEM; Nonpolar Material) by Extraction and Gravimetry," Revision A, February 1999, USEPA publication number EPA-821/R-98-002, NTIS document number PB99-121949, or Revision B, February 2010, USEPA publication number EPA-821/R-10-001, NTIS document number PB2011-100735, USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

BOARD NOTE: Also available on the Internet for free download as a PDF document from the USEPA website at: water.epa.gov/scitech/methods/cwa/methods_index.cfm. Revision A is also from the USEPA, National Service Center for Environmental Publications (NSCEP) website at www.epa.gov/nscep/index.html.

"Methods for Chemical Analysis of Water and Wastes," Third Edition, March 1983, USEPA document number EPA-600/4-79-020, NTIS document number PB84-128677, referenced in 35 Ill. Adm. Code 725.192.

BOARD NOTE: Also available on the Internet as a viewable/printable HTML document from the USEPA website at: www.epa.gov/clariton/clhtml/pubtitleORD.html as document 600479002.

"North American Industry Classification System," July 2007, U.S. Department of Commerce, Bureau of the Census, document number PB2007-100002 (hardcover printed volume) or PB2007-500023, referenced in Section 720.110 (definition of "NAICS Code") for the purposes of Section 720.142.

BOARD NOTE: Also available on the Internet from the Bureau of Census: www.census.gov/naics/2007/naicod07.htm.

"Procedures Manual for Ground Water Monitoring at Solid Waste Disposal Facilities," August 1977, EPA-530/SW-611, NTIS document number PB84-174820, referenced in 35 Ill. Adm. Code 725.192.

"Screening Procedures for Estimating the Air Quality Impact of Stationary Sources," October 1992, USEPA publication number EPA-454/R-92-019, NTIS document number 93-219095, referenced in 35 Ill. Adm. Code 726.204 and 726.206.

BOARD NOTE: Also available on the Internet for free download as a WordPerfect document from the USEPA website at the following Internet address: www.epa.gov/scram001/guidance/guide/scrng.wpd.

"Test Methods for Evaluating Solid Waste, Physical/Chemical Methods," USEPA publication number EPA-530/SW-846 (Third Edition, November 1986; Revision 6, January 2005), as amended by Updates I (July 1992), II (November 1994), IIA (August 1993), IIB (January 1995), III (December 1996), IIIA (April 1998), and IIIB (November 2004) (document number 955-001-00000-1), generally referenced in Appendices A and I to 35 Ill. Adm. Code 721 and 35 Ill. Adm. Code 726.200, 726.206, 726.212, and 728.106 (in addition to the references cited below for specific methods):

Method 0010 (November 1986) (Modified Method 5 Sampling Train), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 0011 (December 1996) (Sampling for Selected Aldehyde and Ketone Emissions from Stationary Sources), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721 and for Appendix I to 35 Ill. Adm. Code 726.

Method 0020 (November 1986) (Source Assessment Sampling System), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 0023A (December 1996) (Sampling Method for Polychlorinated Dibenzo-p-Dioxins and Polychlorinated Dibenzofuran Emissions from Stationary Sources), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721, Appendix I to 35 Ill. Adm. Code 726, and 35 Ill. Adm. Code 726.204.

Method 0030 (November 1986) (Volatile Organic Sampling Train), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 0031 (December 1996) (Sampling Method for Volatile Organic Compounds (SMVOC)), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 0040 (December 1996) (Sampling of Principal Organic Hazardous Constituents from Combustion Sources Using Tedlar® Bags), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 0050 (December 1996) (Isokinetic HCl/Cl_2 Emission Sampling Train), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721, Appendix I to 35 Ill. Adm. Code 726, and 35 Ill. Adm. Code 726.207.

Method 0051 (December 1996) (Midget Impinger HCl/Cl_2 Emission Sampling Train), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721, Appendix I to 35 Ill. Adm. Code 726, and 35 Ill. Adm. Code 726.207.

Method 0060 (December 1996) (Determination of Metals in Stack Emissions), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721, Appendix I to 35 Ill. Adm. Code 726, and 35 Ill. Adm. Code 726.206.

Method 0061 (December 1996) (Determination of Hexavalent Chromium Emissions from Stationary Sources), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721, 35 Ill. Adm. Code 726.206, and Appendix I to 35 Ill. Adm. Code 726.

Method 1010A (November 2004) (Test Methods for Flash Point by Pensky-Martens Closed Cup Tester), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 1020B (November 2004) (Standard Test Methods for Flash Point by Setaflash (Small Scale) Closed-cup Apparatus), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 1110A (November 2004) (Corrosivity Toward Steel), USEPA-approved for 35 Ill. Adm. Code 721.122 and Appendix I to 35 Ill. Adm. Code 721.

Method 1310B (November 2004) (Extraction Procedure (EP) Toxicity Test Method and Structural Integrity Test), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721 and referenced in Appendix I to 35 Ill. Adm. Code 728.

Method 1311 (November 1992) (Toxicity Characteristic Leaching Procedure), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721; for 35 Ill. Adm. Code 721.124, 728.107, and 728.140; and for Table T to 35 Ill. Adm. Code 728.

Method 1312 (November 1994) (Synthetic Precipitation Leaching Procedure), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 1320 (November 1986) (Multiple Extraction Procedure), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 1330A (November 1992) (Extraction Procedure for Oily Wastes), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 9010C (November 2004) (Total and Amenable Cyanide: Distillation), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721 and 35 Ill. Adm. Code 728.140, 728.144, and 728.148, referenced in Table H to 35 Ill. Adm. Code 728.

Method 9012B (November 2004) (Total and Amenable Cyanide (Automated Colorimetric, with Off-Line Distillation)), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721 and 35 Ill. Adm. Code 728.140, 728.144, and 728.148, referenced in Table H to 35 Ill. Adm. Code 728.

Method 9040C (November 2004) (pH Electrometric Measurement), USEPA-approved for 35 Ill. Adm. Code 721.122 and Appendix I to 35 Ill. Adm. Code 721.

Method 9045D (November 2004) (Soil and Waste pH), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 9060A (November 2004) (Total Organic Carbon), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721 and 35 Ill. Adm. Code 724.934, 724.963, 725.934, and 725.963.

Method 9070A (November 2004) (n-Hexane Extractable Material (HEM) for Aqueous Samples), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 9071B (April 1998) (n-Hexane Extractable Material (HEM) for Sludge, Sediment, and Solid Samples), USEPA-approved for Appendix I to 35 Ill. Adm. Code 721.

Method 9095B (November 2004) (Paint Filter Liquids Test), USEPA-approved for 35 Ill. Adm. Code 720.110; Appendix I to 35 Ill. Adm. Code 721; and 35 Ill. Adm. Code 724.290, 724.414, 725.290, 725.414, 725.981, 727.290, and 728.132.

BOARD NOTE: Also available on the Internet for free download in segments in PDF format from the USEPA website at: www.epa.gov/SW-846.

OECD. Organisation for Economic Co-operation and Development, Environment Directorate, 2 rue Andre Pascal, F-75775 Paris Cedex 16, France, +33 (0) 1 45 24 81 67 (www.oecd.org), also OECD Washington Center, 2001 L Street, NW, Suite 650, Washington, DC 20036-4922, 202-785-6323 or 800-456-6323 (www.oecdwash.org):

OECD Guidance Manual. "Guidance Manual for the Implementation of Council Decision C(2001)107/FINAL, as Amended, on the Control of Transboundary Movements of Wastes Destined for Recovery Operations," 2009 (also called "Guidance Manual for the Control of Transboundary Movements of Recoverable Materials" in OECD documents), but only the following segments, which set forth the substantive requirements of OECD decision C(2001)107/FINAL (June 14, 2001), as amended by C(2001)107/ADD1 (February 28, 2002), C(2004)20 (March 9, 2004), C(2005)141 (December 2, 2005), and C(2008)156 (December 4, 2008):

"Annex A: OECD Decision C(2001)107/FINAL, as Amended by C(2004)20; C(2005)141; and C(2008)156" (also called "Revision of Council Decision C(92)39/FINAL on the Control of Transboundary Movements of Wastes Destined for Recovery Operations," within the text of Annex A, and "Decision of the Council Concerning the Control of Transboundary Movements of Wastes Destined for Recovery Operations" in the original OECD decision source document, C(2001)107/FINAL (June 14, 2001), as amended by C(2001)107/ADD1 (February 28, 2002), C(2004)20 (March 9, 2004), C(2005)141 (December 2, 2005), and C(2008)156 (December 4, 2008)).

"Annex B: OECD Consolidated List of Wastes Subject to the Green Control Procedure" (individually referred to as "Annex B to OECD Guidance Manual" in 35 Ill. Adm. Code 722), combining Appendix 3 to OECD decision C(2001)107/FINAL, as amended as described above, together with the text of Annex IX ("List B") to the "Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal" ("Basel Convention").

"Annex C: OECD Consolidated List of Wastes Subject to the Amber Control Procedure" (individually referred to as "Annex C to OECD Guidance Manual" in 35 Ill. Adm. Code 722), combining Appendix 4 to OECD decision C(2001)107/FINAL, as amended, together with the text of Annexes II ("Categories of Wastes Requiring Special Consideration") and VIII ("List A") to the Basel Convention.

BOARD NOTE: The OECD Guidance Manual is available online from OECD at www.oecd.org/dataoecd/57/1/42262259.pdf. The OECD and the Basel Convention consider the OECD Guidance Manual unofficial text of these documents. Despite this unofficial status, the Board has chosen to follow USEPA's lead and incorporate the OECD Guidance Manual by reference, instead of separately incorporating the OECD decision C(2001)107/FINAL (with its subsequent amendments: OECD decisions

C(2001)107/ADD1, C(2004)20, C(2005)141, and C(2008)156) and the Basel Convention by reference. Use of the OECD Guidance Manual eases reference to the documents, increases access to the documents, and facilitates future updates to this incorporation by reference. All references to "OECD C(2001)107/FINAL" in the text of 35 Ill. Adm. Code 722 refer to both the OECD decision and the Basel Convention that the OECD decision references. The OECD Guidance Manual includes as Annex A the full text of OECD document C(2001)107/FINAL, with amendments, and Annexes B and C set forth lists of wastes subject to Green control procedures and wastes subject to Amber control procedures, respectively, which consolidate the wastes from C(2001)107/FINAL together with those from the Basel Convention.

OECD Guideline for Testing of Chemicals, "Ready Biodegradability," Method 301B (July 17, 1992), "CO_2 Evolution (Modified Sturm Test), " referenced in 35 Ill. Adm. Code 724.414.

STI. Available from the Steel Tank Institute, 728 Anthony Trail, Northbrook, IL 60062, 708-498-1980:

"Standard for Dual Wall Underground Steel Storage Tanks" (1986), referenced in 35 Ill. Adm. Code 724.293.

USDOD. Available from the United States Department of Defense:

"DOD Ammunition and Explosives Safety Standards" (DOD 6055.09-STD), as in effect on February 29, 2008, referenced in 35 Ill. Adm. Code 726.305.

"The Motor Vehicle Inspection Report" (DD Form 626), as in effect in March 2007, referenced in 35 Ill. Adm. Code 726.303.

"Requisition Tracking Form" (DD Form 1348), as in effect in July 1991, referenced in 35 Ill. Adm. Code 726.303.

"The Signature and Tally Record" (DD Form 1907), as in effect in November 2006, referenced in 35 Ill. Adm. Code 726.303.

"Dangerous Goods Shipping Paper/Declaration and Emergency Response Information for Hazardous Materials Transported by Government Vehicles" (DD Form 836), as in effect in December 2007, referenced in 35 Ill. Adm. Code 726.303.

BOARD NOTE: DOD 6055.09-STD is available on-line for download in pdf format from http://www.ddesb.pentagon.mil. DD Form 1348, DD Form 1907, DD Form 836, and DOD 6055.09-STD are available on-line for download in pdf format from http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm.

USEPA, Office of Ground Water and Drinking Water. Available from United States Environmental Protection Agency, Office of Drinking Water, State Programs Division, WH 550 E, Washington, D.C. 20460:

"Inventory of Injection Wells," USEPA Form 7520-16 (Revised 8-01), referenced in 35 Ill. Adm. Code 704.148 and 704.283.

"Technical Assistance Document: Corrosion, Its Detection and Control in Injection Wells," USEPA publication number EPA-570/9-87-002, August 1987, referenced in 35 Ill. Adm. Code 730.165.

USEPA, Receptor Analysis Branch. Available from Receptor Analysis Branch, USEPA (MD-14), Research Triangle Park, NC 27711:

"Screening Procedures for Estimating the Air Quality Impact of Stationary Sources, Revised," October 1992, USEPA publication number EPA-450/R-92-019, USEPA-approved for Appendix I to 35 Ill. Adm. Code 726.

BOARD NOTE: Also available for purchase from NTIS (see above) and on the Internet for free download as a WordPerfect document from the USEPA website at following Internet address: www.epa.gov/scram001/guidance/guide/scrng.wpd.

USEPA Region 6. Available from United States Environmental Protection Agency, Region 6, Multimedia Permitting and Planning Division, 1445 Ross Avenue, Dallas, TX 75202 (phone: 214-665-7430):

"EPA RCRA Delisting Program – Guidance Manual for the Petitioner,"

March 23, 2000, referenced in Section 720.122.

USGSA. Available from the United States Government Services Administration:

Government Bill of Lading (GBL) (GSA Standard Form 1103, rev 9/2003, supplemented as necessary with GSA Standard Form 1109, rev 09/1998), referenced in Section 726.303.

BOARD NOTE: Available on-line for download in various formats from www.gsa.gov/forms/forms.htm.

b) Code of Federal Regulations. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20401, 202-783-3238:

10 CFR 20.2006 (2013) (Transfer for Disposal and Manifests), referenced in 35 Ill. Adm. Code 726.425 and 726.450.

Table II, column 2 in appendix B to 10 CFR 20 (2013) (Water Effluent Concentrations), referenced in 35 Ill. Adm. Code 702.110, 730.103, and 730.151.

Appendix G to 10 CFR 20 (2013) (Requirements for Transfers of Low-Level Radioactive Waste Intended for Disposal at Licensed Land Disposal Facilities and Manifests), referenced in 35 Ill. Adm. Code 726.440.

10 CFR 71 (2013), as amended at 78 Fed. Reg. 16922 (Mar. 19, 2013)~~77 Fed. Reg. 39899 (July 6, 2012)~~ (Packaging and Transportation of Radioactive Material), referenced generally in 35 Ill. Adm. Code 726.430.

10 CFR 71.5 (2013) (Transportation of Licensed Material), referenced in 35 Ill. Adm. Code 726.425.

33 CFR 153.203 (2013) (Procedure for the Notice of Discharge), referenced in 35 Ill. Adm. Code 723.130 and 739.143.

40 CFR 3.3 (2013)~~(2012)~~ (What Definitions Are Applicable to This Part?), referenced in Section 720.104.

40 CFR 3.10 (2013)~~(2012)~~ (What Are the Requirements for Electronic Reporting to EPA?), referenced in Section 720.104.

40 CFR 3.2000 (2013)~~(2012)~~ (What Are the Requirements Authorized State, Tribe, and Local Programs' Reporting Systems Must Meet?), referenced in Section 720.104.

40 CFR 51.100(ii) (2013)~~(2012)~~ (Definitions), referenced in 35 Ill. Adm. Code 726.200.

Appendix W to 40 CFR 51 (2013)~~(2012)~~ (Guideline on Air Quality Models), referenced in 35 Ill. Adm. Code 726.204.

BOARD NOTE: Also available from NTIS (see above for contact information) as "Guideline on Air Quality Models," Revised 1986, USEPA publication number EPA-450/12-78-027R, NTIS document numbers PB86-245248 (Guideline) and PB88-150958 (Supplement).

Appendix B to 40 CFR 52.741 (2013)~~(2012)~~ (VOM Measurement Techniques for Capture Efficiency), referenced in 35 Ill. Adm. Code 703.213, 703.352, 724.982, 724.984, 724.986, 724.989, 725.983, 725.985, 725.987, and 725.990.

40 CFR 60 (2013), as amended at 78 Fed. Reg. 58415 (Sept. 19, 2013) and 78 Fed. Reg. 76753 (Dec. 19, 2013)~~(2012), as amended at 77 Fed. Reg. 44488 (July 30, 2012); 77 Fed. Reg. 48433 (Aug. 14, 2012); 77 Fed. Reg. 49489 (Aug. 16, 2012); 77 Fed. Reg. 56421 (Sept. 12, 2012)~~ (Standards of Performance for New Stationary Sources), referenced generally in 35 Ill. Adm. Code 724.964, 724.980, 725.964, and 725.980.

Subpart VV of 40 CFR 60 (2013)~~(2012)~~ (Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry), referenced in 35 Ill. Adm. Code 724.989 and 725.990.

Appendix A to 40 CFR 60 (2013)~~(2012)~~ (Test Methods), referenced generally in 35 Ill. Adm. Code 726.205 (in addition to the references cited below for specific methods):

Method 1 (Sample and Velocity Traverses for Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 2 (Determination of Stack Gas Velocity and Volumetric Flow Rate (Type S Pitot Tube)), referenced in 35 Ill. Adm. Code 724.933, 724.934, 725.933, 725.934, and 726.205.

Method 2A (Direct Measurement of Gas Volume through Pipes and Small Ducts), referenced in 35 Ill. Adm. Code 724.933, 725.933, and 726.205.

Method 2B (Determination of Exhaust Gas Volume Flow Rate from Gasoline Vapor Incinerators), referenced in 35 Ill. Adm. Code 726.205.

Method 2C (Determination of Gas Velocity and Volumetric Flow Rate in Small Stacks or Ducts (Standard Pitot Tube)), referenced in 35 Ill. Adm. Code 724.933, 725.933, and 726.205.

Method 2D (Measurement of Gas Volume Flow Rates in Small Pipes and Ducts), referenced in 35 Ill. Adm. Code 724.933, 725.933, and 726.205.

Method 2E (Determination of Landfill Gas Production Flow Rate), referenced in 35 Ill. Adm. Code 726.205.

Method 2F (Determination of Stack Gas Velocity and Volumetric Flow Rate with Three-Dimensional Probes), referenced in 35 Ill. Adm. Code 726.205.

Method 2G (Determination of Stack Gas Velocity and Volumetric Flow Rate with Two-Dimensional Probes), referenced in 35 Ill. Adm. Code 726.205.

Method 2H (Determination of Stack Gas Velocity Taking into Account Velocity Decay Near the Stack Wall), referenced in 35 Ill. Adm. Code 726.205.

Method 3 (Gas Analysis for the Determination of Dry Molecular Weight), referenced in 35 Ill. Adm. Code 724.443 and 726.205.

Method 3A (Determination of Oxygen and Carbon Dioxide Concentrations in Emissions from Stationary Sources

(Instrumental Analyzer Procedure)), referenced in 35 Ill. Adm. Code 726.205.

Method 3B (Gas Analysis for the Determination of Emission Rate Correction Factor or Excess Air), referenced in 35 Ill. Adm. Code 726.205.

Method 3C (Determination of Carbon Dioxide, Methane, Nitrogen, and Oxygen from Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 4 (Determination of Moisture Content in Stack Gases), referenced in 35 Ill. Adm. Code 726.205.

Method 5 (Determination of Particulate Matter Emissions from Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 5A (Determination of Particulate Matter Emissions from the Asphalt Processing and Asphalt Roofing Industry), referenced in 35 Ill. Adm. Code 726.205.

Method 5B (Determination of Nonsulfuric Acid Particulate Matter Emissions from Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 5D (Determination of Particulate Matter Emissions from Positive Pressure Fabric Filters), referenced in 35 Ill. Adm. Code 726.205.

Method 5E (Determination of Particulate Matter Emissions from the Wool Fiberglass Insulation Manufacturing Industry), referenced in 35 Ill. Adm. Code 726.205.

Method 5F (Determination of Nonsulfate Particulate Matter Emissions from Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 5G (Determination of Particulate Matter Emissions from Wood Heaters (Dilution Tunnel Sampling Location)), referenced in 35 Ill. Adm. Code 726.205.

Method 5H (Determination of Particulate Emissions from Wood Heaters from a Stack Location), referenced in 35 Ill. Adm. Code 726.205.

Method 5I (Determination of Low Level Particulate Matter Emissions from Stationary Sources), referenced in 35 Ill. Adm. Code 726.205.

Method 18 (Measurement of Gaseous Organic Compound Emissions by Gas Chromatography), referenced in 35 Ill. Adm. Code 724.933, 724.934, 725.933, and 725.934.

Method 21 (Determination of Volatile Organic Compound Leaks), referenced in 35 Ill. Adm. Code 703.213, 724.934, 724.935, 724.963, 725.934, 725.935, 725.963, and 725.984.

Method 22 (Visual Determination of Fugitive Emissions from Material Sources and Smoke Emissions from Flares), referenced in 35 Ill. Adm. Code 724.933, 724.1101, 725.933, 725.1101, and 727.900.

Method 25A (Determination of Total Gaseous Organic Concentration Using a Flame Ionization Analyzer), referenced in 35 Ill. Adm. Code 724.934 and 725.985.

Method 25D (Determination of the Volatile Organic Concentration of Waste Samples), referenced in 35 Ill. Adm. Code 724.982, 725.983, and 725.984.

Method 25E (Determination of Vapor Phase Organic Concentration in Waste Samples), referenced in 35 Ill. Adm. Code 725.984.

Method 27 (Determination of Vapor Tightness of Gasoline Delivery Tank Using Pressure-Vacuum Test), referenced in 35 Ill. Adm. Code 724.986 and 725.987.

40 CFR 61 (20013)~~(2012)~~ (National Emission Standards for Hazardous Air Pollutants), referenced generally in 35 Ill. Adm. Code 724.933, 724.964, 725.933, 725.964, and 725.980.

Subpart V of 40 CFR 61 (2013)~~(2012)~~ (National Emission Standard for Equipment Leaks (Fugitive Emission Sources)), referenced in 35 Ill. Adm. Code 724.989 and 725.990.

Subpart FF of 40 CFR 61 (2013)~~(2012)~~ (National Emission Standard for Benzene Waste Operations), referenced in 35 Ill. Adm. Code 724.982 and 725.983.

40 CFR 63 (2013), as amended at 78 Fed. Reg. 79317 (Dec. 30, 2013)~~(2012), as amended at 77 Fed. Reg. 41075 (July 12, 2012); 77 Fed. Reg. 49489 (Aug. 16, 2012); 77 Fed. Reg. 55698 (Sept. 11, 2012); 77 Fed. Reg. 58219 (Sept. 19, 2012); 77 Fed. Reg. 65135 (Oct. 25, 2012); 77 Fed. Reg. 75739 (Dec. 21, 2012)~~ (National Emission Standards for Hazardous Air Pollutants for Source Categories), referenced generally in 35 Ill. Adm. Code 724.933, 724.964, 724.980, 725.933, 725.964, 725.980, and 726.200.

Subpart RR of 40 CFR 63 (2013)~~(2012)~~ (National Emission Standards for Individual Drain Systems), referenced in 35 Ill. Adm. Code 724.984, 724.985, 725.985, and 725.986.

Subpart EEE of 40 CFR 63 (2000) (National Emission Standards for Hazardous Air Pollutants from Hazardous Waste Combustors), referenced in 35 Ill. Adm. Code 703.280.

Subpart EEE of 40 CFR 63 (2013)~~(2012)~~ (National Emission Standards for Hazardous Air Pollutants from Hazardous Waste Combustors) (includes 40 CFR 63.1206 (When and How Must You Comply with the Standards and Operating Requirements?), 63.1215 (What are the Health-Based Compliance Alternatives for Total Chlorine?), 63.1216 (What are the Standards for Solid-Fuel Boilers that Burn Hazardous Waste?), 63.1217 (What are the Standards for Liquid-Fuel Boilers that Burn Hazardous Waste?), 63.1218 (What are the Standards for Hydrochloric Acid Production Furnaces that Burn Hazardous Waste?), 63.1219 (What are the Replacement Standards for Hazardous Waste Incinerators?), 63.1220 (What are the Replacement Standards for Hazardous Waste-

Burning Cement Kilns?), and 63.1221 (What are the Replacement Standards for Hazardous Waste-Burning Lightweight Aggregate Kilns?)), referenced in Appendix A to 35 Ill. Adm. Code 703 and 35 Ill. Adm. Code 703.155, 703.205, 703.208, 703.221, 703.232, 703.320, 703.280, 724.440, 724.701, 724.950, 725.440, and 726.200.

Method 301 (Field Validation of Pollutant Measurement Methods from Various Waste Media) in appendix A to 40 CFR 63 (2013)~~(2012)~~ (Test Methods), referenced in 35 Ill. Adm. Code 725.984.

Appendix C to 40 CFR 63 (2013)~~(2012)~~ (Determination of the Fraction Biodegraded (F_{bio}) in a Biological Treatment Unit), referenced in 35 Ill. Adm. Code 725.984.

Appendix D to 40 CFR 63 (2013)~~(2012)~~ (Test Methods), referenced in 35 Ill. Adm. Code 725.984.

40 CFR 136.3 (Identification of Test Procedures) (2013)~~(2012)~~, referenced in 35 Ill. Adm. Code 702.110, 704.150, 704.187, and 730.103.

40 CFR 144.70 (2013)~~(2012)~~ (Wording of the Instruments), referenced in 35 Ill. Adm. Code 704.240.

40 CFR 232.2 (2013)~~(2012)~~ (Definitions), referenced in 35 Ill. Adm. Code 721.104.

40 CFR 257 (2013)~~(2012)~~ (Criteria for Classification of Solid Waste Disposal Facilities and Practices), referenced in 35 Ill. Adm. Code 739.181.

Subpart B of 40 CFR 257 (2013) (Disposal Standards for the Receipt of Conditionally Exempt Small Quantity Generator (CESQG) Wastes at Non-Municipal Non-Hazardous Waste Disposal Units) (40 CFR 257.5 through 257.30), referenced in 35 Ill. Adm. Code 721.105.

40 CFR 258 (2013)~~(2012)~~ (Criteria for Municipal Solid Waste Landfills), referenced in 35 Ill. Adm. Code 739.181.

40 CFR 260.21(b) (2013)~~(2012)~~ (Alternative Equivalent Testing Methods), referenced in Section 720.121.

40 CFR 261.151 (2013)~~(2012)~~ (Wording of the Instruments), referenced in 35 Ill. Adm. Code 721.251.

Appendix III to 40 CFR 261 (2013)~~(2012)~~ (Chemical Analysis Test Methods), referenced in 35 Ill. Adm. Code 704.150 and 704.187.

40 CFR 262.53 (2013)~~(2012)~~ (Notification of Intent to Export), referenced in 35 Ill. Adm. Code 722.153.

40 CFR 262.54 (2013)~~(2012)~~ (Special Manifest Requirements), referenced in 35 Ill. Adm. Code 722.154.

40 CFR 262.55 (2013)~~(2012)~~ (Exception Reports), referenced in 35 Ill. Adm. Code 722.155.

40 CFR 262.56 (2013)~~(2012)~~ (Annual Reports), referenced in 35 Ill. Adm. Code 722.156.

40 CFR 262.57 (2013)~~(2012)~~ (Recordkeeping), referenced in 35 Ill. Adm. Code 722.157.

Appendix to 40 CFR 262 (2013)~~(2012)~~ (Uniform Hazardous Waste Manifest and Instructions (EPA Forms 8700-22 and 8700-22A and Their Instructions)), referenced in Appendix A to 35 Ill. Adm. Code 722 and 35 Ill. Adm. Code 724.986 and 725.987.

40 CFR 264.151 (2013)~~(2012)~~ (Wording of the Instruments), referenced in 35 Ill. Adm. Code 724.251 and 727.240.

Appendix I to 40 CFR 264 (2013)~~(2012)~~ (Recordkeeping Instructions), referenced in Appendix A to 35 Ill. Adm. Code 724.

Appendix IV to 40 CFR 264 (2013)~~(2012)~~ (Cochran's Approximation to the Behrens-Fisher Students' T-Test), referenced in Appendix D to 35 Ill. Adm. Code 724.

Appendix V to 40 CFR 264 (2013)~~(2012)~~ (Examples of Potentially Incompatible Waste), referenced in Appendix E to 35 Ill. Adm. Code 724 and 35 Ill. Adm. Code 727.270.

Appendix VI to 40 CFR 264 (2013)~~(2012)~~ (Political Jurisdictions in Which Compliance with Section264.18(a) Must Be Demonstrated), referenced in 35 Ill. Adm. Code 703.306, 724.118, and 727.110.

Appendix I to 40 CFR 265 (2013)~~(2012)~~ (Recordkeeping Instructions), referenced in Appendix A to 35 Ill. Adm. Code 725.

Appendix III to 40 CFR 265 (2013)~~(2012)~~ (EPA Interim Primary Drinking Water Standards), referenced in Appendix C to 35 Ill. Adm. Code 725.

Appendix IV to 40 CFR 265 (2013)~~(2012)~~ (Tests for Significance), referenced in Appendix D to 35 Ill. Adm. Code 725.

Appendix V to 40 CFR 265 (2013)~~(2012)~~ (Examples of Potentially Incompatible Waste), referenced in 35 Ill. Adm. Code 725.277, 725.301, 725.330, 725.357, 725.382, and 725.413 and Appendix E to 35 Ill. Adm. Code 725.

Appendix IX to 40 CFR 266 (2013)~~(2012)~~ (Methods Manual for Compliance with the BIF Regulations), referenced generally in Appendix I to 35 Ill. Adm. Code 726.

Section 4.0 (Procedures for Estimating the Toxicity Equivalence of Chlorinated Dibenzo-p-Dioxin and Dibenzofuran Congeners), referenced in 35 Ill. Adm. Code 726.200 and 726.204.

Section 5.0 (Hazardous Waste Combustion Air Quality Screening Procedure), referenced in 35 Ill. Adm. Code 726.204 and 726.206.

Section 7.0 (Statistical Methodology for Bevill Residue Determinations), referenced in 35 Ill. Adm. Code 726.212.

BOARD NOTE: Also available from NTIS (see above for contact information) as "Methods Manual for Compliance with BIF Regulations: Burning Hazardous Waste in Boilers and Industrial Furnaces," December 1990, USEPA publication number EPA-530/SW-91-010, NTIS document number PB91-120006.

40 CFR 267.151 (2013)~~(2012)~~ (Wording of the Instruments), referenced in 35 Ill. Adm. Code 727.240.

40 CFR 270.5 (2013)~~(2012)~~ (Noncompliance and Program Reporting by the Director), referenced in 35 Ill. Adm. Code 703.305.

40 CFR 761 (2013)~~(2012), as amended at 77 Fed. Reg. 46289 (Aug. 3, 2012); 77 Fed. Reg. 54818 (Sept. 6, 2012)~~ (Polychlorinated Biphenyls (PCBs) Manufacturing, Processing, Distribution in Commerce, and Use Prohibitions), referenced generally in 35 Ill. Adm. Code 728.145.

40 CFR 761.3 (2013)~~(2012), as amended at 77 Fed. Reg. 46289 (Aug. 3, 2012); 77 Fed. Reg. 54818 (Sept. 6, 2012)~~ (Definitions), referenced in 35 Ill. Adm. Code 728.102 and 739.110.

40 CFR 761.60 (2013)~~(2012)~~ (Disposal Requirements), referenced in 35 Ill. Adm. Code 728.142.

40 CFR 761.65 (2013)~~(2012), as amended at 77 Fed. Reg. 46289 (Aug. 3, 2012); 77 Fed. Reg. 54818 (Sept. 6, 2012)~~ (Storage for Disposal), referenced in 35 Ill. Adm. Code 728.150.

40 CFR 761.70 (2013)~~(2012), as amended at 77 Fed. Reg. 46289 (Aug. 3, 2012); 77 Fed. Reg. 54818 (Sept. 6, 2012)~~ (Incineration), referenced in 35 Ill. Adm. Code 728.142.

Subpart B of 49 CFR 107 (2013)~~(2012)~~ (Exemptions), referenced generally in 35 Ill. Adm. Code 724.986 and 725.987.

49 CFR 171 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 2, 2013) and 78 Fed. Reg. 65454 (Oct. 31, 2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (General Information, Regulations, and Definitions), referenced generally in 35 Ill. Adm. Code 721.104, 733.118, 733.138, 733.152, and 739.143.

49 CFR 171.3 (2013)~~(2012)~~ (Hazardous Waste), referenced in 35 Ill. Adm. Code 722.133.

49 CFR 171.8 (2013), as amended at 78 Fed. Reg. 65454 (Oct. 31, 2013)~~(2012)~~ (Definitions and Abbreviations), referenced in 35 Ill. Adm. Code 733.118, 733.138, 733.152, 733.155, and 739.143.

49 CFR 171.15 (2013)~~(2012)~~ (Immediate Notice of Certain Hazardous Materials Incidents), referenced in 35 Ill. Adm. Code 723.130 and 739.143.

49 CFR 171.16 (2013)~~(2012)~~ (Detailed Hazardous Materials Incident Reports), referenced in 35 Ill. Adm. Code 723.130 and 739.143.

49 CFR 172 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 2, 2013), 78 Fed. Reg. 65454 (Oct. 31, 2013), and 78 Fed. Reg. 69310 (Nov. 19, 2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Hazardous Materials Table, Special Provisions, Hazardous Materials Communications, Emergency Response Information, and Training Requirements), referenced generally in 35 Ill. Adm. Code 721.104, 722.131, 722.132, 724.986, 725.987, 733.114, 733.118, 733.134, 733.138, 733.152, 733.155, and 739.143.

49 CFR 172.304 (2013)~~(2012)~~ (Marking Requirements), referenced in 35 Ill. Adm. Code 722.132.

Subpart F of 49 CFR 172 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 2, 2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Placarding), referenced in 35 Ill. Adm. Code 722.133.

49 CFR 173 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 2, 2013) and 78 Fed. Reg. 65454 (Oct. 31, 2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Shippers – General Requirements for Shipments and Packages), referenced generally in 35 Ill. Adm. Code 721.104, 722.130, 724.416, 724.986, 725.416, 725.987, 733.118, 733.138, 733.152, and 739.143.

49 CFR 173.2 (2013)~~(2012)~~ (Hazardous Materials Classes and Index to Hazard Class Definitions), referenced in 35 Ill. Adm. Code 733.152.

49 CFR 173.12 (2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Exceptions for Shipments of Waste Materials), referenced in 35 Ill. Adm. Code 724.416, 724.986, 725.416, and 725.987.

49 CFR 173.28 (2013)~~(2012)~~ (Reuse, Reconditioning, and Remanufacture of Packagings), referenced in 35 Ill. Adm. Code 725.273.

49 CFR 173.50 (2013)~~(2012)~~ (Class 1 − Definitions), referenced in 35 Ill. Adm. Code 721.123.

49 CFR 173.54 (2013)~~(2012)~~ (Forbidden Explosives), referenced in 35 Ill. Adm. Code 721.123.

49 CFR 173.115 (2013)~~(2012)~~ (Class 2, Divisions 2.1, 2.2, and 2.3 − Definitions), referenced in 35 Ill. Adm. Code 721.121.

49 CFR 173.127 (2013)~~(2012)~~ (Class 2, Divisions 2.1, 2.2, and 2.3 – Definitions), referenced in 35 Ill. Adm. Code 721.121.

49 CFR 174 (2013)~~(2012)~~ (Carriage by Rail), referenced generally in 35 Ill. Adm. Code 733.118, 733.138, 733.152, and 739.143.

49 CFR 175 (2013), as amended at 78 Fed. Reg. 65454 (Oct. 31, 2013) ~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Carriage by Aircraft), referenced generally in 35 Ill. Adm. Code 733.118, 733.138, 733.152, and 739.143.

49 CFR 176 (2013) as amended at 78 Fed. Reg. 65454 (Oct. 31, 2013) ~~(2012)~~ (Carriage by Vessel), referenced generally in 35 Ill. Adm. Code 733.118, 733.138, 733.152, and 739.143.

49 CFR 177 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 31, 2013)~~(2012)~~ (Carriage by Public Highway), referenced generally in 35 Ill. Adm. Code 733.118, 733.138, 733.152, and 739.143.

49 CFR 178 (2013), as amended at 78 Fed. Reg. 60745 (Oct. 2, 2013) and 78 Fed. Reg. 65454 (Oct. 31, 2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Specifications for Packagings), referenced generally in 35 Ill. Adm. Code 721.104, 722.130, 724.416, 724.986, 725.416, 725.987, 733.118, 733.138, 733.152, and 739.143.

49 CFR 179 (2013)~~(2012), as amended at 77 Fed. Reg. 60935 (Oct. 5, 2012)~~ (Specifications for Tank Cars), referenced in 35 Ill. Adm. Code

721.104, 722.130, 724.416, 724.986, 725.416, 725.987, 733.118, 733.138, 733.152, and 739.143.

49 CFR 180 (2013)~~(2012)~~ (Continuing Qualification and Maintenance of Packagings), referenced generally in 35 Ill. Adm. Code 724.986, 725.987, 733.118, 733.138, 733.152, and 739.143.

49 CFR 190 (2013) (Pipeline Safety Programs and Rulemaking Procedures), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 191 (2013) (Transportation of Natural and Other Gas by Pipeline: Annual Reports, Incident Reports, and Safety-Related Condition Reports), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 192 (2013) (Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 193 (2013) (Liquefied Natural Gas Facilities: Federal Safety Standards), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 194 (2013) (Response Plans for Onshore Oil Pipelines), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 195 (2013) (Transportation of Hazardous Liquids by Pipeline), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 198 (2013) (Regulations for Grants to Aid State Pipeline Safety Programs), referenced generally in 35 Ill. Adm. Code 721.104.

49 CFR 199 (2013) (Drug and Alcohol Testing), referenced generally in 35 Ill. Adm. Code 721.104

c) Federal Statutes:

Section 11 of the Atomic Energy Act of 1954 (42 USC 2014)(2011), referenced in 35 Ill. Adm. Code 721.104 and 726.310.

Sections 201(v), 201(w), and 512(j) of the Federal Food, Drug, and Cosmetic Act (FFDCA; 21 USC 321(v), 321(w), and 360b(j))

(2012)~~(2011)~~, referenced in Section 720.110 and 35 Ill. Adm. Code 733.109.

Chapter 601 of subtitle VIII of 49 USC (49 USC 60101 through 60140) (2011), referenced in 35 Ill. Adm. Code 721.104.

Section 1412 of the Department of Defense Authorization Act of 1986 (50 USC 1521(j)(1)) (2011), referenced in 35 Ill. Adm. Code 726.301.

d) This Section incorporates no later editions or amendments.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Identification and Listing of Hazardous Waste

2) Code citation: 35 Ill. Adm. Code 721

3)

Section Numbers:	Proposed Action:
721.104	Amend
721.105	Amend

4) Statutory Authority: 415 ILCS 5/7.2, 22.4 and 27

5) A Complete Description of the Subjects and Issues Involved: This rulemaking is a single segment of the docket R14-13 rulemaking that also affects 35 Ill. Adm. Code 720, which is covered by a separate notice in this issue of the *Illinois Register*. To save space, a more detailed description of the subjects and issues involved in the docket R14-13 rulemaking in this issue of the *Illinois Register* only in the answer to question 5 in the Notice of Proposed Amendments for 35 Ill. Adm. Code 720. A comprehensive description is contained in the Board's opinion and order of February 6, 2014, proposing amendments in docket R14-13, which opinion and order is available from the address below.

Specifically, this rulemaking implements segments of the federal amendments of July 31, 2013 and January 3, 2014. The amendments add the texts of the conditional exclusions. The Board has included a limited number of corrections and clarifying revisions that are not directly derived from the instant federal amendments.

Tables appear in the Board's opinion and order of February 6, 2014 in docket R14-13 that list numerous corrections and revisions that are not based on current federal amendments. The tables contain deviations from the literal text of the federal amendments underlying these amendments, as well as corrections and clarifications that the Board made in the base text involved. Persons interested in the details of those corrections and revisions should refer to the February 6, 2014 opinion and order in docket R14-13.

Section 22.4 of the Environmental Protection Act [415 ILCS 5/22.4] provides that Section 5-35 of the Administrative Procedure Act [5 ILCS 100/5-35] does not apply to this rulemaking. Because this rulemaking is not subject to Section 5-35 of the APA, it is not subject to First Notice or to Second Notice review by the Joint Committee on Administrative Rules (JCAR).

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

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

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

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

9) Does this rulemaking contain incorporations by reference? No

10) Statement of Statewide Policy Objectives: These proposed amendments do not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

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

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: The Board will accept written public comment on this proposal for a period of 45 days after the date of this publication. Comments should reference docket R14-13 and be addressed to:

John T. Therriault, Clerk
Illinois Pollution Control Board
State of Illinois Center, Suite 11-500
100 W. Randolph St.
Chicago, IL 60601

Please direct inquiries to the following person and reference docket R14-13:

Michael J. McCambridge
Staff Attorney
Illinois Pollution Control Board
100 W. Randolph 11-500
Chicago, IL 60601

312/814-6924
e-mail: mccambm@ipcb.state.il.us

Request copies of the Board's opinion and order at 312-814-3620, or download a copy from the Board's Website at http:\\www.ipcb.state.il.us.

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities, and not-for-profit corporations affected: This rulemaking may affect those small businesses, small municipalities, and not-for-profit corporations that generate, transport, treat, store, or dispose of hazardous waste. These proposed amendments do not create or enlarge a state mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

B) Reporting, bookkeeping or other procedures required for compliance: The existing rules and the proposed amendments require extensive reporting, bookkeeping and other procedures, including the preparation of manifests and annual reports, waste analyses and maintenance of operating records. These proposed amendments do not create or enlarge a state mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

C) Types of professional skills necessary for compliance: Compliance with the existing rules and the proposed amendments may require the services of an attorney, certified public accountant, chemist, and registered professional engineer. These proposed amendments do not create or enlarge a state mandate, as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805/3(b) (2012)].

14) Regulatory Agenda on which this rulemaking was summarized: January 2014: published at 37 Ill. Reg. 20463, 20501 (December 20, 2013)

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

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER c: HAZARDOUS WASTE OPERATING REQUIREMENTS

PART 721
IDENTIFICATION AND LISTING OF HAZARDOUS WASTE

SUBPART A: GENERAL PROVISIONS

Section
721.101 Purpose and Scope
721.102 Definition of Solid Waste
721.103 Definition of Hazardous Waste
721.104 Exclusions
721.105 Special Requirements for Hazardous Waste Generated by Small Quantity Generators
721.106 Requirements for Recyclable Materials
721.107 Residues of Hazardous Waste in Empty Containers
721.108 PCB Wastes Regulated under TSCA
721.109 Requirements for Universal Waste

SUBPART B: CRITERIA FOR IDENTIFYING THE CHARACTERISTICS OF HAZARDOUS WASTE AND FOR LISTING HAZARDOUS WASTES

Section
721.110 Criteria for Identifying the Characteristics of Hazardous Waste
721.111 Criteria for Listing Hazardous Waste

SUBPART C: CHARACTERISTICS OF HAZARDOUS WASTE

Section
721.120 General
721.121 Characteristic of Ignitability
721.122 Characteristic of Corrosivity
721.123 Characteristic of Reactivity
721.124 Toxicity Characteristic

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

SUBPART D: LISTS OF HAZARDOUS WASTE

Section
721.130 General
721.131 Hazardous Wastes from Nonspecific Sources
721.132 Hazardous Waste from Specific Sources
721.133 Discarded Commercial Chemical Products, Off-Specification Species, Container Residues, and Spill Residues Thereof
721.135 Wood Preserving Wastes

SUBPART E: EXCLUSIONS AND EXEMPTIONS

Section
721.138 Exclusion of Comparable Fuel and Syngas Fuel
721.139 Conditional Exclusion for Used, Broken CRTs and Processed CRT Glass Undergoing Recycling
721.140 Conditional Exclusion for Used, Intact CRTs Exported for Recycling
721.141 Notification and Recordkeeping for Used, Intact CRTs Exported for Reuse

SUBPART H: FINANCIAL REQUIREMENTS FOR MANAGEMENT OF EXCLUDED HAZARDOUS SECONDARY MATERIALS

Section
721.240 Applicability
721.241 Definitions of Terms as Used in This Subpart
721.242 Cost Estimate
721.243 Financial Assurance Condition
721.247 Liability Requirements
721.248 Incapacity of Owners or Operators, Guarantors, or Financial Institutions
721.249 Use of State-Required Mechanisms
721.250 State Assumption of Responsibility
721.251 Wording of the Instruments

721.APPENDIX A Representative Sampling Methods
721.APPENDIX B Method 1311 Toxicity Characteristic Leaching Procedure (TCLP) (Repealed)
721.APPENDIX C Chemical Analysis Test Methods (Repealed)
721.TABLE A Analytical Characteristics of Organic Chemicals (Repealed)
721.TABLE B Analytical Characteristics of Inorganic Species (Repealed)
721.TABLE C Sample Preparation/Sample Introduction Techniques (Repealed)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENTS

721.APPENDIX G	Basis for Listing Hazardous Wastes
721.APPENDIX H	Hazardous Constituents
721.APPENDIX I	Wastes Excluded by Administrative Action
721.TABLE A	Wastes Excluded by USEPA pursuant to 40 CFR 260.20 and 260.22 from Non-Specific Sources
721.TABLE B	Wastes Excluded by USEPA pursuant to 40 CFR 260.20 and 260.22 from Specific Sources
721.TABLE C	Wastes Excluded by USEPA pursuant to 40 CFR 260.20 and 260.22 from Commercial Chemical Products, Off-Specification Species, Container Residues, and Soil Residues Thereof
721.TABLE D	Wastes Excluded by the Board by Adjusted Standard
721.APPENDIX J	Method of Analysis for Chlorinated Dibenzo-p-Dioxins and Dibenzofurans (Repealed)
721.APPENDIX Y	Table to Section 721.138: Maximum Contaminant Concentration and Minimum Detection Limit Values for Comparable Fuel Specification
721.APPENDIX Z	Table to Section 721.102: Recycled Materials that Are Solid Waste

AUTHORITY: Implementing Sections 7.2 and 22.4 and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/7.2, 22.4 and 27].

SOURCE: Adopted in R81-22 at 5 Ill. Reg. 9781, effective May 17, 1982; amended and codified in R81-22 at 6 Ill. Reg. 4828, effective May 17, 1982; amended in R82-18 at 7 Ill. Reg. 2518, effective February 22, 1983; amended in R82-19 at 7 Ill. Reg. 13999, effective October 12, 1983; amended in R84-34, 61 at 8 Ill. Reg. 24562, effective December 11, 1984; amended in R84-9 at 9 Ill. Reg. 11834, effective July 24, 1985; amended in R85-22 at 10 Ill. Reg. 998, effective January 2, 1986; amended in R85-2 at 10 Ill. Reg. 8112, effective May 2, 1986; amended in R86-1 at 10 Ill. Reg. 14002, effective August 12, 1986; amended in R86-19 at 10 Ill. Reg. 20647, effective December 2, 1986; amended in R86-28 at 11 Ill. Reg. 6035, effective March 24, 1987; amended in R86-46 at 11 Ill. Reg. 13466, effective August 4, 1987; amended in R87-32 at 11 Ill. Reg. 16698, effective September 30, 1987; amended in R87-5 at 11 Ill. Reg. 19303, effective November 12, 1987; amended in R87-26 at 12 Ill. Reg. 2456, effective January 15, 1988; amended in R87-30 at 12 Ill. Reg. 12070, effective July 12, 1988; amended in R87-39 at 12 Ill. Reg. 13006, effective July 29, 1988; amended in R88-16 at 13 Ill. Reg. 382, effective December 27, 1988; amended in R89-1 at 13 Ill. Reg. 18300, effective November 13, 1989; amended in R90-2 at 14 Ill. Reg. 14401, effective August 22, 1990; amended in R90-10 at 14 Ill. Reg. 16472, effective September 25, 1990; amended in R90-17 at 15 Ill. Reg. 7950, effective May 9, 1991; amended in R90-11 at 15 Ill. Reg. 9332, effective June 17, 1991; amended in R91-1 at 15 Ill. Reg. 14473, effective September 30, 1991; amended in R91-12 at 16 Ill. Reg. 2155, effective January 27, 1992; amended in R91-26 at 16 Ill. Reg. 2600, effective February 3, 1992;

amended in R91-13 at 16 Ill. Reg. 9519, effective June 9, 1992; amended in R92-1 at 16 Ill. Reg. 17666, effective November 6, 1992; amended in R92-10 at 17 Ill. Reg. 5650, effective March 26, 1993; amended in R93-4 at 17 Ill. Reg. 20568, effective November 22, 1993; amended in R93-16 at 18 Ill. Reg. 6741, effective April 26, 1994; amended in R94-7 at 18 Ill. Reg. 12175, effective July 29, 1994; amended in R94-17 at 18 Ill. Reg. 17490, effective November 23, 1994; amended in R95-6 at 19 Ill. Reg. 9522, effective June 27, 1995; amended in R95-20 at 20 Ill. Reg. 10963, effective August 1, 1996; amended in R96-10/R97-3/R97-5 at 22 Ill. Reg. 275, effective December 16, 1997; amended in R98-12 at 22 Ill. Reg. 7615, effective April 15, 1998; amended in R97-21/R98-3/R98-5 at 22 Ill. Reg. 17531, effective September 28, 1998; amended in R98-21/R99-2/R99-7 at 23 Ill. Reg. 1718, effective January 19, 1999; amended in R99-15 at 23 Ill. Reg. 9135, effective July 26, 1999; amended in R00-13 at 24 Ill. Reg. 9481, effective June 20, 2000; amended in R01-3 at 25 Ill. Reg. 1281, effective January 11, 2001; amended in R01-21/R01-23 at 25 Ill. Reg. 9108, effective July 9, 2001; amended in R02-1/R02-12/R02-17 at 26 Ill. Reg. 6584, effective April 22, 2002; amended in R03-18 at 27 Ill. Reg. 12760, effective July 17, 2003; amended in R04-16 at 28 Ill. Reg. 10693, effective July 19, 2004; amended in R05-8 at 29 Ill. Reg. 6003, effective April 13, 2005; amended in R06-5/R06-6/R06-7 at 30 Ill. Reg. 2992, effective February 23, 2006; amended in R06-16/R06-17/R06-18 at 31 Ill. Reg. 791, effective December 20, 2006; amended in R07-5/R07-14 at 32 Ill. Reg. 11786, effective July 14, 2008; amended in R09-3 at 33 Ill. Reg. 986, effective December 30, 2008; amended in R09-16/R10-4 at 34 Ill. Reg. 18611, effective November 12, 2010; amended in R11-2/R11-16 at 35 Ill. Reg. 17734, effective October 14, 2011; amended in R13-5 at 37 Ill. Reg. 3213, effective March 4, 2013; amended in R14-13 at 38 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 721.104 Exclusions

a) Materials that are not solid wastes. The following materials are not solid wastes for the purpose of this Part:

1) Sewage.

A) Domestic sewage (untreated sanitary wastes that pass through a sewer system); and

B) Any mixture of domestic sewage and other waste that passes through a sewer system to publicly-owned treatment works for treatment.

2) Industrial wastewater discharges that are point source discharges with National Pollutant Discharge Elimination System (NPDES) permits issued by the Agency pursuant to Section 12(f) of the Environmental Protection Act [415 ILCS 5/12(f)] and 35 Ill. Adm. Code 309.

BOARD NOTE: This exclusion applies only to the actual point source discharge. It does not exclude industrial wastewaters while they are being collected, stored, or treated before discharge, nor does it exclude sludges that are generated by industrial wastewater treatment.

3) Irrigation return flows.

4) Source, by-product, or special nuclear material, as defined by section 11 of the Atomic Energy Act of 1954, as amended (42 USC 2014), incorporated by reference in 35 Ill. Adm. Code 720.111(b).

5) Materials subjected to in-situ mining techniques that are not removed from the ground as part of the extraction process.

6) Pulping liquors (i.e., black liquors) that are reclaimed in a pulping liquor recovery furnace and then reused in the pulping process, unless it is accumulated speculatively, as defined in Section 721.101(c).

7) Spent sulfuric acid used to produce virgin sulfuric acid, unless it is accumulated speculatively, as defined in Section 721.101(c).

8) Secondary materials that are reclaimed and returned to the original process or processes in which they were generated, where they are reused in the production process, provided that the following is true:

A) Only tank storage is involved, and the entire process through completion of reclamation is closed by being entirely connected with pipes or other comparable enclosed means of conveyance;

B) Reclamation does not involve controlled flame combustion (such as occurs in boilers, industrial furnaces, or incinerators);

C) The secondary materials are never accumulated in such tanks for over 12 months without being reclaimed; and

D) The reclaimed material is not used to produce a fuel or used to produce products that are used in a manner constituting disposal.

9) Wood preserving wastes.

A) Spent wood preserving solutions that have been used and which are reclaimed and reused for their original intended purpose;

B) Wastewaters from the wood preserving process that have been reclaimed and which are reused to treat wood; and

C) Prior to reuse, the wood preserving wastewaters and spent wood preserving solutions described in subsections (a)(9)(A) and (a)(9)(B) of this Section, so long as they meet all of the following conditions:

i) The wood preserving wastewaters and spent wood preserving solutions are reused on-site at water-borne plants in the production process for their original intended purpose;

ii) Prior to reuse, the wastewaters and spent wood preserving solutions are managed to prevent release to either land or groundwater or both;

iii) Any unit used to manage wastewaters or spent wood preserving solutions prior to reuse can be visually or otherwise determined to prevent such releases;

iv) Any drip pad used to manage the wastewaters or spent wood preserving solutions prior to reuse complies with the standards in Subpart W of 35 Ill. Adm. Code 725, regardless of whether the plant generates a total of less than 100 kg/month of hazardous waste; and

v) Prior to operating pursuant to this exclusion, the plant owner or operator prepares a one-time notification to the Agency stating that the plant intends to claim the exclusion,

giving the date on which the plant intends to begin operating under the exclusion, and containing the following language: "I have read the applicable regulation establishing an exclusion for wood preserving wastewaters and spent wood preserving solutions and understand it requires me to comply at all times with the conditions set out in the regulation." The plant must maintain a copy of that document in its on-site records until closure of the facility. The exclusion applies only so long as the plant meets all of the conditions. If the plant goes out of compliance with any condition, it may apply to the Agency for reinstatement. The Agency must reinstate the exclusion in writing if it finds that the plant has returned to compliance with all conditions and that the violations are not likely to recur. If the Agency denies an application, it must transmit to the applicant specific, detailed statements in writing as to the reasons it denied the application. The applicant under this subsection (a)(9)(C)(v) may appeal the Agency's determination to deny the reinstatement, to grant the reinstatement with conditions, or to terminate a reinstatement before the Board pursuant to Section 40 of the Act [415 ILCS 5/40].

10) Hazardous waste numbers K060, K087, K141, K142, K143, K144, K145, K147, and K148, and any wastes from the coke by-products processes that are hazardous only because they exhibit the toxicity characteristic specified in Section 721.124, when subsequent to generation these materials are recycled to coke ovens, to the tar recovery process as a feedstock to produce coal tar, or are mixed with coal tar prior to the tar's sale or refining. This exclusion is conditioned on there being no land disposal of the waste from the point it is generated to the point it is recycled to coke ovens, to tar recovery, to the tar refining processes, or prior to when it is mixed with coal.

11) Nonwastewater splash condenser dross residue from the treatment of hazardous waste number K061 in high temperature metals recovery units, provided it is shipped in drums (if shipped) and not land disposed before recovery.

12) Certain oil-bearing hazardous secondary materials and recovered oil, as follows:

A) Oil-bearing hazardous secondary materials (i.e., sludges, by-products, or spent materials) that are generated at a petroleum refinery (standard industrial classification (SIC) code 2911) and are inserted into the petroleum refining process (SIC code 2911: including, but not limited to, distillation, catalytic cracking, fractionation, gasification (as defined in 35 Ill. Adm. Code 720.110), or thermal cracking units (i.e., cokers)), unless the material is placed on the land, or speculatively accumulated before being so recycled. Materials inserted into thermal cracking units are excluded under this subsection (a)(12), provided that the coke product also does not exhibit a characteristic of hazardous waste. Oil-bearing hazardous secondary materials may be inserted into the same petroleum refinery where they are generated or sent directly to another petroleum refinery and still be excluded under this provision. Except as provided in subsection (a)(12)(B) of this Section, oil-bearing hazardous secondary materials generated elsewhere in the petroleum industry (i.e., from sources other than petroleum refineries) are not excluded under this Section. Residuals generated from processing or recycling materials excluded under this subsection (a)(12)(A), where such materials as generated would have otherwise met a listing under Subpart D of this Part, are designated as USEPA hazardous waste number F037 listed wastes when disposed of or intended for disposal.

B) Recovered oil that is recycled in the same manner and with the same conditions as described in subsection (a)(12)(A) of this Section. Recovered oil is oil that has been reclaimed from secondary materials (including wastewater) generated from normal petroleum industry practices, including refining, exploration and production, bulk storage, and transportation incident thereto (SIC codes 1311, 1321, 1381, 1382, 1389, 2911, 4612, 4613, 4922, 4923, 4789, 5171, and 5172). Recovered oil does not include oil-bearing hazardous wastes listed in Subpart D of this Part; however, oil recovered from such wastes may be considered recovered oil. Recovered oil does not include used oil, as defined in 35 Ill. Adm. Code 739.100.

13) Excluded scrap metal (processed scrap metal, unprocessed home scrap metal, and unprocessed prompt scrap metal) being recycled.

14) Shredded circuit boards being recycled, provided that they meet the following conditions:

A) The circuit boards are stored in containers sufficient to prevent a release to the environment prior to recovery; and

B) The circuit boards are free of mercury switches, mercury relays, nickel-cadmium batteries, and lithium batteries.

15) Condensates derived from the overhead gases from kraft mill steam strippers that are used to comply with federal Clean Air Act regulation 40 CFR 63.446(e). The exemption applies only to combustion at the mill generating the condensates.

16) Comparable fuels or comparable syngas fuels that meet the requirements of Section 721.138.

17) Spent materials (as defined in Section 721.101) (other than hazardous wastes listed in Subpart D of this Part) generated within the primary mineral processing industry from which minerals, acids, cyanide, water, or other values are recovered by mineral processing or by beneficiation~~benefication~~, provided that the following is true:

A) The spent material is legitimately recycled to recover minerals, acids, cyanide, water, or other values;

B) The spent material is not accumulated speculatively;

C) Except as provided in subsection (a)(17)(D) of this Section, the spent material is stored in tanks, containers, or buildings that meet the following minimum integrity standards: a building must be an engineered structure with a floor, walls, and a roof all of which are made of non-earthen materials providing structural support (except that smelter buildings may have partially earthen floors, provided that the spent material is stored on the non-earthen portion), and

have a roof suitable for diverting rainwater away from the foundation; a tank must be free standing, not be a surface impoundment (as defined in 35 Ill. Adm. Code 720.110), and be manufactured of a material suitable for containment of its contents; a container must be free standing and be manufactured of a material suitable for containment of its contents. If a tank or container contains any particulate that may be subject to wind dispersal, the owner or operator must operate the unit in a manner that controls fugitive dust. A tank, container, or building must be designed, constructed, and operated to prevent significant releases to the environment of these materials.

D) The Agency must allow by permit that solid mineral processing spent materials only may be placed on pads, rather than in tanks, containers, or buildings if the facility owner or operator can demonstrate the following: the solid mineral processing secondary materials do not contain any free liquid; the pads are designed, constructed, and operated to prevent significant releases of the spent material into the environment; and the pads provide the same degree of containment afforded by the non-RCRA tanks, containers, and buildings eligible for exclusion.

i) The Agency must also consider whether storage on pads poses the potential for significant releases via groundwater, surface water, and air exposure pathways. Factors to be considered for assessing the groundwater, surface water, and air exposure pathways must include the following: the volume and physical and chemical properties of the spent material, including its potential for migration off the pad; the potential for human or environmental exposure to hazardous constituents migrating from the pad via each exposure pathway; and the possibility and extent of harm to human and environmental receptors via each exposure pathway.

ii) Pads must meet the following minimum standards: they must be designed of non-earthen material that is compatible with the chemical nature of the mineral processing spent material; they must be capable of withstanding physical

stresses associated with placement and removal; they must have runon and runoff controls; they must be operated in a manner that controls fugitive dust; and they must have integrity assurance through inspections and maintenance programs.

iii) Before making a determination under this subsection (a)(17)(D), the Agency must provide notice and the opportunity for comment to all persons potentially interested in the determination. This can be accomplished by placing notice of this action in major local newspapers, or broadcasting notice over local radio stations.

BOARD NOTE: See Subpart D of 35 Ill. Adm. Code 703 for the RCRA Subtitle C permit public notice requirements.

E) The owner or operator provides a notice to the Agency, providing the following information: the types of materials to be recycled, the type and location of the storage units and recycling processes, and the annual quantities expected to be placed in non-land-based units. This notification must be updated when there is a change in the type of materials recycled or the location of the recycling process.

F) For purposes of subsection (b)(7) of this Section, mineral processing spent materials must be the result of mineral processing and may not include any listed hazardous wastes. Listed hazardous wastes and characteristic hazardous wastes generated by non-mineral processing industries are not eligible for the conditional exclusion from the definition of solid waste.

18) Petrochemical recovered oil from an associated organic chemical manufacturing facility, where the oil is to be inserted into the petroleum refining process (SIC code 2911) along with normal petroleum refinery process streams, provided that both of the following conditions are true of the oil:

A) The oil is hazardous only because it exhibits the characteristic of ignitability (as defined in Section 721.121) or toxicity for benzene

(Section 721.124, USEPA hazardous waste code D018);

B) The oil generated by the organic chemical manufacturing facility is not placed on the land, or speculatively accumulated before being recycled into the petroleum refining process. An "associated organic chemical manufacturing facility" is a facility for which all of the following is true: its primary SIC code is 2869, but its operations may also include SIC codes 2821, 2822, and 2865; it is physically co-located with a petroleum refinery; and the petroleum refinery to which the oil being recycled is returned also provides hydrocarbon feedstocks to the organic chemical manufacturing facility. "Petrochemical recovered oil" is oil that has been reclaimed from secondary materials (i.e., sludges, by-products, or spent materials, including wastewater) from normal organic chemical manufacturing operations, as well as oil recovered from organic chemical manufacturing processes.

19) Spent caustic solutions from petroleum refining liquid treating processes used as a feedstock to produce cresylic or naphthenic acid, unless the material is placed on the land or accumulated speculatively, as defined in Section 721.101(c).

20) Hazardous secondary materials used to make zinc fertilizers, provided that the following conditions are satisfied:

A) Hazardous secondary materials used to make zinc micronutrient fertilizers must not be accumulated speculatively, as defined in Section 721.101(c)(8).

B) A generator or intermediate handler of zinc-bearing hazardous secondary materials that are to be incorporated into zinc fertilizers must fulfill the following conditions:

i) It must submit a one-time notice to the Agency that contains the name, address, and USEPA identification number of the generator or intermediate handler facility, that provides a brief description of the secondary material that will be subject to the exclusion, and which identifies when the manufacturer intends to begin managing excluded

zinc-bearing hazardous secondary materials under the conditions specified in this subsection (a)(20).

ii) It must store the excluded secondary material in tanks, containers, or buildings that are constructed and maintained in a way that prevents releases of the secondary materials into the environment. At a minimum, any building used for this purpose must be an engineered structure made of non-earthen materials that provide structural support, and it must have a floor, walls, and a roof that prevent wind dispersal and contact with rainwater. A tank used for this purpose must be structurally sound and, if outdoors, it must have a roof or cover that prevents contact with wind and rain. A container used for this purpose must be kept closed, except when it is necessary to add or remove material, and it must be in sound condition. Containers that are stored outdoors must be managed within storage areas that fulfill the conditions of subsection (a)(20)(F) of this Section:

iii) With each off-site shipment of excluded hazardous secondary materials, it must provide written notice to the receiving facility that the material is subject to the conditions of this subsection (a)(20).

iv) It must maintain records at the generator's or intermediate handler's facility for no less than three years of all shipments of excluded hazardous secondary materials. For each shipment these records must, at a minimum, contain the information specified in subsection (a)(20)(G) of this Section.

C) A manufacturer of zinc fertilizers or zinc fertilizer ingredients made from excluded hazardous secondary materials must fulfill the following conditions:

i) It must store excluded hazardous secondary materials in accordance with the storage requirements for generators

and intermediate handlers, as specified in subsection (a)(20)(B)(ii) of this Section.

ii) It must submit a one-time notification to the Agency that, at a minimum, specifies the name, address, and USEPA identification number of the manufacturing facility and which identifies when the manufacturer intends to begin managing excluded zinc-bearing hazardous secondary materials under the conditions specified in this subsection (a)(20).

iii) It must maintain for a minimum of three years records of all shipments of excluded hazardous secondary materials received by the manufacturer, which must at a minimum identify for each shipment the name and address of the generating facility, the name of transporter, and the date on which the materials were received, the quantity received, and a brief description of the industrial process that generated the material.

iv) It must submit an annual report to the Agency that identifies the total quantities of all excluded hazardous secondary materials that were used to manufacture zinc fertilizers or zinc fertilizer ingredients in the previous year, the name and address of each generating facility, and the industrial processes from which the hazardous secondary materials were generated.

D) Nothing in this Section preempts, overrides, or otherwise negates the provision in 35 Ill. Adm. Code 722.111 that requires any person who generates a solid waste to determine if that waste is a hazardous waste.

E) Interim status and permitted storage units that have been used to store only zinc-bearing hazardous wastes prior to the submission of the one-time notice described in subsection (a)(20)(B)(i) of this Section, and that afterward will be used only to store hazardous secondary materials excluded under this subsection (a)(20), are not

subject to the closure requirements of 35 Ill. Adm. Code 724 and 725.

F) A container used to store excluded secondary material must fulfill the following conditions:

i) It must have containment structures or systems sufficiently impervious to contain leaks, spills, and accumulated precipitation;

ii) It must provide for effective drainage and removal of leaks, spills, and accumulated precipitation; and

iii) It must prevent run-on into the containment system.

BOARD NOTE: Subsections (a)(20)(F)(i) through (a)(20)(F)(iii) are derived from 40 CFR 261.4(a)(20)(ii)(B)(*1*) through (a)(20)(ii)(B)(*3*). The Board added the preamble to these federal paragraphs as subsection (a)(20)(F) to comport with Illinois Administrative Code codification requirements.

G) Required records of shipments of excluded hazardous secondary materials must, at a minimum, contain the following information:

i) The name of the transporter and date of the shipment;

ii) The name and address of the facility that received the excluded material, along with documentation confirming receipt of the shipment; and

iii) The type and quantity of excluded secondary material in each shipment.

BOARD NOTE: Subsections (a)(20)(G)(i) through (a)(20)(G)(iii) are derived from 40 CFR 261.4(a)(20)(ii)(D)(*1*) through (a)(20)(ii)(D)(*3*). The Board added the preamble to these federal paragraphs as subsection (a)(20)(G) to comport with Illinois Administrative Code codification requirements.

21) Zinc fertilizers made from hazardous wastes or hazardous secondary materials that are excluded under subsection (a)(20) of this Section, provided that the following conditions are fulfilled:

A) The fertilizers meet the following contaminant limits:

i) For metal contaminants:

Constituent	Maximum Allowable Total Concentration in Fertilizer, per Unit (1%) of Zinc (ppm)
Arsenic	0.3
Cadmium	1.4
Chromium	0.6
Lead	2.8
Mercury	0.3

ii) For dioxin contaminants, the fertilizer must contain no more than eight parts per trillion of dioxin, measured as toxic equivalent (TEQ).

B) The manufacturer performs sampling and analysis of the fertilizer product to determine compliance with the contaminant limits for metals no less frequently than once every six months, and for dioxins no less frequently than once every 12 months. Testing must also be performed whenever changes occur to manufacturing processes or ingredients that could significantly affect the amounts of contaminants in the fertilizer product. The manufacturer may use any reliable analytical method to demonstrate that no constituent of concern is present in the product at concentrations above the applicable limits. It is the responsibility of the manufacturer to ensure that the sampling and analysis are unbiased, precise, and representative of the products introduced into commerce.

C) The manufacturer maintains for no less than three years records of all sampling and analyses performed for purposes of determining compliance with subsection (a)(21)(B) of this Section. Such records must at a minimum include the following:

i) The dates and times product samples were taken, and the dates the samples were analyzed;

ii) The names and qualifications of the persons taking the samples;

iii) A description of the methods and equipment used to take the samples;

iv) The name and address of the laboratory facility at which analyses of the samples were performed;

v) A description of the analytical methods used, including any cleanup and sample preparation methods; and

vi) All laboratory analytical results used to determine compliance with the contaminant limits specified in this subsection (a)(21).

22) Used CRTs.

A) Used, intact CRTs, as defined in 35 Ill. Adm. Code 720.110, are not solid waste within the United States, unless they are disposed of or speculatively accumulated, as defined in Section 721.101(c)(8), by a CRT collector or glass processor.

B) Used, intact CRTs, as defined in 35 Ill. Adm. Code 720.110, are not solid waste when exported for recycling, provided that they meet the requirements of Section 721.140.

C) Used, broken CRTs, as defined in 35 Ill. Adm. Code 720.110, are not solid waste, provided that they meet the requirements of Section 721.139.

D) Glass removed from CRTs is not a solid waste provided that it meets the requirements of Section 721.139(c).

23) Hazardous secondary materials managed in land-based units. Hazardous secondary material generated and reclaimed within the United States or its territories and managed in land-based units, as defined in 35 Ill. Adm. Code 720.110, is not a solid waste if the following conditions are fulfilled with regard to the material:

A) The material is contained;

B) The material is a hazardous secondary material generated and reclaimed under the control of the generator, as defined in 35 Ill. Adm. Code 720.110;

C) The material is not speculatively accumulated, as defined in Section 721.101(c)(8);

D) The material is not otherwise subject to material-specific management conditions under subsection (a) of this Section when reclaimed, it is not a spent lead acid battery (see 35 Ill. Adm. Code 726.180 and 733.102), and it does not meet either of the listing descriptions for K171 or K172 waste in Section 721.132;

E) The reclamation of the material is legitimate, as determined pursuant to 35 Ill. Adm. Code 720.143; and

F) In addition, a person claiming the exclusion under this subsection (a)(23) must provide notification of regulated waste activity, as required by 35 Ill. Adm. Code 720.142. (For hazardous secondary material managed in a non-land-based unit, see Section 721.102(a)(2)(B)).

24) Hazardous secondary materials transferred for off-site recycling. Hazardous secondary material that is generated and then transferred to another person for the purpose of reclamation is not a solid waste if the management of the material fulfills the conditions of subsections (a)(24)(A) through (a)(24)(G) of this Section:

A) The hazardous secondary material must not be speculatively accumulated, as defined in Section 721.110).

B) No person or facility other than the hazardous secondary material generator, the transporter, an intermediate facility, or a reclaimer manages the material; the material must not be stored for more than 10 days at a transfer facility, as defined in Section 721.110; and the material must be packaged according to applicable USDOT regulations codified as 49 CFR 173, 178, and 179, incorporated by reference in 35 Ill. Adm. Code 720.111, while in transport.

C) The hazardous secondary material must not otherwise be subject to material-specific management conditions pursuant to other provisions of this subsection (a) when reclaimed; the material must not be a spent lead-acid battery (see 35 Ill. Adm. Code 726.180 and 733.102); and the material must not fulfill either of the listing descriptions for K171 or K172 waste in Section 721.132.

D) The reclamation of the hazardous secondary material must be legitimate, as determined pursuant to 35 Ill. Adm. Code 720.143.

E) The hazardous secondary material generator must satisfy each of the following conditions:

i) The hazardous secondary material must be contained.

ii) This subsection (a)(24)(E)(ii) applies when non-RCRA management of hazardous secondary material will occur at a reclamation facility or transfer facility. For the purposes of this subsection (a)(24), "non-Subtitle C management" is management of the hazardous secondary material that is not addressed under a RCRA Part B permit or under the interim status facility standards (of 35 Ill. Adm. Code 725 or similar regulations authorized by USEPA as equivalent to 40 CFR 265). Prior to arranging for transport of hazardous secondary materials to a reclamation facility where non-Subtitle C management will occur, the hazardous secondary material generator must make reasonable efforts to ensure that the reclaimer intends to properly and legitimately reclaim the hazardous secondary material and not discard it, and that the reclaimer will manage the hazardous

secondary material in a manner that is protective of human health and the environment. If the hazardous secondary material will pass through an intermediate facility where non-RCRA management will occur, the hazardous secondary material generator must make contractual arrangements with the intermediate facility to ensure that the hazardous secondary material is sent to the reclamation facility identified by the hazardous secondary material generator, and the hazardous secondary material generator must perform reasonable efforts to ensure that the intermediate facility will manage the hazardous secondary material in a manner that is protective of human health and the environment. Reasonable efforts must be repeated at a minimum of once every three years for the hazardous secondary material generator to claim the exclusion of this subsection (a)(24) and to send the hazardous secondary materials to a reclaimer and any intermediate facility. In making these reasonable efforts, the generator may use any credible evidence available, including information gathered by the hazardous secondary material generator, provided by the reclaimer or intermediate facility, or provided by a third party. The hazardous secondary material generator must make the series of affirmative determinations set forth in subsection (a)(24)(H) of this Section for each reclamation facility and intermediate facility that will manage its waste.

BOARD NOTE: Corresponding 40 CFR 261.4(a)(24)(v)(B) makes it clear that USEPA intends that the generator undertake this determination for each reclaimer that will manage its hazardous secondary material. The Board added a definition of "non-Subtitle C management" and substituted this term for the language "management of the hazardous secondary materials is not addressed under a RCRA Part B permit or interim status standards." Although the Board shifted the language for enhanced readability, the Board intends no shift in meaning. The Board moved the material from 40 CFR 261.4(a)(24)(v)(B)(1) through (a)(24)(v)(B)(5) to appear as 35 Ill. Adm. Code 721.104(a)(24)(H)(i) through

(a)(24)(H)(v). This movement allowed compliance with codification requirements relating to the maximum permissible indent level.

iii) The hazardous secondary material generator must execute a certification statement that includes the following language, together with the printed name and official title of an authorized representative of the hazardous secondary material generator, the authorized representative's signature, and the date signed:

> "I hereby certify in good faith and to the best of my knowledge that, prior to arranging for transport of excluded hazardous secondary materials to [insert the name of each reclamation facility and any intermediate facility that will manage the materials], reasonable efforts were made in accordance with 35 Ill. Adm. Code 721.104(a)(24)(E)(ii) (and corresponding 40 CFR 261.4(a)(24)(v)(B)) to ensure that the hazardous secondary materials would be recycled legitimately and would be otherwise managed in a manner that is protective of human health and the environment, and that such efforts were based on current and accurate information."

BOARD NOTE: Corresponding 40 CFR 261.4(a)(24)(v)(C) combines the requirements for records retention and availability for inspection with the requirement for certification. The Board combined the certification requirements from 40 CFR 261.4(a)(24)(v)(C), (a)(24)(v)(C)(1), and (a)(24)(v)(C)(2) in this single subsection (a)(24)(E)(iii). This combination allowed compliance with codification requirements relating to the maximum permissible indent level. The Board moved the records retention and availability for inspection requirements to subsection (a)(24)(E)(iv) of this Section. This forced renumbering 40 CFR 261.4(a)(24)(v)(D) and (a)(24)(v)(E) as subsections (a)(24)(E)(v) and

(a)(24)(E)(vi) of this Section. Although the Board shifted the language for enhanced readability, the Board intends no shift in meaning.

iv) The hazardous secondary material generator must maintain the following records for a minimum of three years: documentation and certification that the generator made reasonable efforts, prior to transferring hazardous secondary material, for each reclamation facility and, if applicable, intermediate facility where non-Subtitle C management of the hazardous secondary materials will occur. Documentation and certification must be made available, within 72 hours, or within any longer period of time specified by the Agency, upon request by the Agency.

BOARD NOTE: The Board moved the records retention and availability for inspection requirements of corresponding 40 CFR 261.4(a)(24)(v)(C) to this subsection (a)(24)(E)(iv).

v) The hazardous secondary material generator must maintain certain records at the generating facility for a minimum of three years that document every off-site shipment of hazardous secondary materials. The documentation for each shipment must, at a minimum, include the following information about the shipment: the name of the transporter and date of the shipment; the name and address of each reclaimer and intermediate facility to which the hazardous secondary material was sent; and the type and quantity of hazardous secondary material in the shipment.

BOARD NOTE: The Board combined and moved the shipping documentation and records retention requirements of corresponding 40 CFR 261.4(a)(24)(v)(D) and (a)(24)(v)(D)(1) through (a)(24)(v)(D)(3) to this single subsection (a)(24)(E)(v). This combination allowed compliance with codification requirements relating to the maximum permissible indent level.

vi) The hazardous secondary material generator must maintain at the generating facility, for a minimum of three years, for every off-site shipment of hazardous secondary materials, confirmations of receipt from each reclaimer and intermediate facility to which its hazardous secondary materials were sent. Each confirmation of receipt must include the name and address of the reclaimer (or intermediate facility), the type and quantity of the hazardous secondary materials received, and the date on which the facility received the hazardous secondary materials. The generator may satisfy this requirement using routine business records (e.g., financial records, bills of lading, copies of DOT shipping papers, or electronic confirmations of receipt).

BOARD NOTE: The Board moved the shipment confirmation documentation and records retention requirements of corresponding 40 CFR 261.4(a)(24)(v)(E) to this subsection (a)(24)(E)(vi).

F) The reclaimer of hazardous secondary material or any intermediate facility, as defined in 35 Ill. Adm. Code 720.110, that manages material which is excluded from regulation pursuant to this subsection (a)(24) must satisfy all of the following conditions:

i) The owner or operator of a reclamation or intermediate facility must maintain at its facility for a minimum of three years records of every shipment of hazardous secondary material that the facility received and, if applicable, for every shipment of hazardous secondary material that the facility received and subsequently sent off-site from the facility for further reclamation. For each shipment, these records must, at a minimum, contain the following information: the name of the transporter and date of the shipment; the name and address of the hazardous secondary material generator and, if applicable, the name and address of the reclaimer or intermediate facility from which the facility received the hazardous secondary materials; the type and quantity of hazardous secondary material in the

shipment; and, for hazardous secondary materials that the facility subsequently transferred off-site for further reclamation after receiving it, the name and address of the (subsequent) reclaimer and any intermediate facility to which the facility sent the hazardous secondary material.

BOARD NOTE: The Board combined the provisions from 40 CFR 261.4(a)(24)(vi)(A) and (a)(24)(vi)(A)(1) through (a)(24)(vi)(A)(3) that enumerate the required information into this single subsection (a)(24)(F)(i). This combination allowed compliance with codification requirements relating to the maximum permissible indent level.

ii) The intermediate facility must send the hazardous secondary material to the reclaimers designated by the generator of the hazardous secondary materials.

iii) The reclaimer or intermediate facility that receives a shipment of hazardous secondary material must send a confirmation of receipt to the hazardous secondary material generator for each off-site shipment of hazardous secondary materials. A confirmation of receipt must include the name and address of the reclaimer (or intermediate facility), the type and quantity of the hazardous secondary materials received, and the date on which the facility received the hazardous secondary materials. The reclaimer or intermediate facility may satisfy this requirement using routine business records (e.g., financial records, bills of lading, copies of DOT shipping papers, or electronic confirmations of receipt).

iv) The reclaimer or intermediate facility must manage the hazardous secondary material in a manner that is at least as protective of human health and the environment as that employed for analogous raw material, and the material must be contained. An "analogous raw material" is a raw material for which the hazardous secondary material substitutes and that serves the same function and has

similar physical and chemical properties as the hazardous secondary material.

v) A reclaimer of hazardous secondary materials must manage any residuals that are generated from its reclamation processes in a manner that is protective of human health and the environment. If any residuals of the reclamation process exhibit a characteristic of hazardous waste, as defined in Subpart C of this Part, or if the residuals themselves are specifically listed as hazardous waste in Subpart D of this Part, those residuals are hazardous waste. The reclaimer and any subsequent persons must manage that hazardous waste in accordance with the applicable requirements of 35 Ill. Adm. Code: Subtitle G or similar regulations authorized by USEPA as equivalent to 40 CFR 260 through 272.

vi) The reclaimer and intermediate facility must have financial assurance that satisfies the requirements of Subpart H of this Part.

G) Any person claiming the exclusion for recycled hazardous secondary material pursuant to this subsection (a)(24) must provide notification as required by 35 Ill. Adm. Code 720.142.

H) For the purposes of subsection (a)(24)(E)(ii) of this Section, the hazardous secondary material generator must affirmatively determine that each of the following conditions is true for each reclamation facility and any intermediate facility that will manage the generator's hazardous secondary material:

i) Available information indicates that the reclamation process is legitimate recycling, as determined pursuant to 35 Ill. Adm. Code 720.143. In making this determination, the hazardous secondary material generator may rely on its existing knowledge of the physical and chemical properties of the hazardous secondary material, as well as on information from other sources (e.g., the reclamation facility, audit reports, etc.) about the reclamation process.

(By making this determination, the hazardous secondary material generator has also satisfied the requirement in 35 Ill. Adm. Code 720.143(a) that the generator demonstrate that the recycling is legitimate).

ii) Publicly available information indicates that each reclamation facility and any intermediate facility that is used by the hazardous secondary material generator has submitted the notification required by 35 Ill. Adm. Code 720.142, and these facilities have submitted the required proofs of financial assurance as required by the applicable of Section 721.243(a)(1), (b)(1), (c)(1), (d)(1), (e)(3), and (g) and notification of financial assurance pursuant to 35 Ill. Adm. Code 720.142(a)(5). In making this dual determination, the hazardous secondary material generator may rely on the available information documenting the reclamation facility's and any intermediate facility's compliance with the notification requirements pursuant to 35 Ill. Adm. Code 720.142, including the requirement in 35 Ill. Adm. Code 720.142(a)(5) to notify the Agency whether the reclaimer or intermediate facility has financial assurance.

iii) Publicly available information indicates that each reclamation facility and any intermediate facility that is used by the hazardous secondary material generator has not had any formal enforcement actions taken against the facility within the previous three years for violations of the RCRA hazardous waste regulations, and the facility has not been classified as a significant non-complier (SNC) with RCRA Subtitle C requirements. In making this determination, the hazardous secondary material generator may rely on the publicly available information from USEPA, the Agency, or the Office of the Attorney General. If the reclamation facility or any intermediate facility that is used by the hazardous secondary material generator has had a formal enforcement action taken against the facility within the previous three years for violations of the RCRA hazardous waste regulations, or if the facility has been

classified as a SNC with RCRA Subtitle C requirements, the hazardous secondary material generator must have credible evidence that the facility will manage the hazardous secondary materials properly. In making this determination, the hazardous secondary material generator can obtain additional information from USEPA, the Agency, the Office of the Attorney General, or the facility itself which indicates that the facility has addressed the violations, taken remedial steps to address the violations and prevent future violations, or that the violations are not relevant to the proper management of the generator's hazardous secondary materials.

BOARD NOTE: USEPA or a state may make a formalized determination that a facility is a SNC (pronounced "snick") pursuant to USEPA's "Hazardous Waste Civil Enforcement Response Policy" (most recent version: December 2003, available from USEPA, Envirofacts Data Warehouse (www.epa.gov/compliance/resources/policies/civil/rcra/finalerp1203.pdf)). USEPA operates the online RCRAInfo database (www.epa.gov/enviro/html/rcris/) from which interested persons can learn whether a facility has significant federal enforcement action against it, or if it is a SNC.

iv) Available information indicates that the reclamation facility and any intermediate facility used by the hazardous secondary material generator have the equipment and trained personnel to safely recycle the hazardous secondary material. In making this determination, the generator may rely on a description made by the reclamation facility or an independent third party of the equipment and trained personnel that the facility will use to manage and recycle the generator's hazardous secondary material.

v) If residuals are generated from the reclamation of the excluded hazardous secondary materials, the reclamation facility has the permits required (if any) to manage the residuals. If the reclamation facility does not have required

permits, the facility has a contract with an appropriately permitted facility to dispose of the residuals. If the reclamation facility does not have required permits or a contract with a permitted facility, the hazardous secondary material generator has credible evidence that the residuals will be managed in a manner that is protective of human health and the environment. In making these determinations, the hazardous secondary material generator may rely on publicly available information from USEPA or the Agency, or on information provided by the facility itself.

BOARD NOTE: The Board moved 40 CFR 261.4(a)(24)(v)(B)(1) through (a)(24)(v)(B)(5) to appear as 35 Ill. Adm. Code 721.104(a)(24)(H)(i) through (a)(24)(H)(v), which set forth the determinations mandated for the purposes of subsection (a)(24)(E)(ii). This movement allowed compliance with codification requirements relating to the maximum permissible indent level.

25) Hazardous secondary materials exported for recycling. Hazardous secondary material that is exported from the United States and reclaimed at a reclamation facility located in a foreign country is not a solid waste, so long as the hazardous secondary material generator complies with the applicable requirements of subsections (a)(24)(A) through (a)(24)(E) of this Section, except that the requirements of subsection (a)(24)(H)(ii) of this Section (requiring the use of publicly available information to verify that the facility has submitted required notifications) do not apply to foreign reclaimers and intermediate facilities, and the hazardous secondary material generator also complies with the following requirements:

A) The generator must notify the Agency and USEPA of an intended export before the hazardous secondary material is scheduled to leave the United States. The generator must submit a complete notification at least 60 days before the initial shipment is intended to be shipped off-site. This notification may cover export activities extending over a period up to 12 months in duration, but not longer. The notification must be in writing and signed by the

hazardous secondary material generator, and must include the following information:

i) The name, mailing address, telephone number and USEPA identification number (if applicable) of the hazardous secondary material generator;

ii) A description of the hazardous secondary material; the USEPA hazardous waste number that would apply were the hazardous secondary material to be managed as hazardous waste; and the USDOT proper shipping name, hazard class, and identification number (UN or NA number) for each hazardous secondary material, as identified in 49 CFR 171 through 173, each incorporated by reference in 35 Ill. Adm. Code 720.111;

iii) The estimated frequency or rate at which the hazardous secondary material is to be exported, and the period of time over which the hazardous secondary material is to be exported;

iv) The estimated total quantity of hazardous secondary material;

v) All points of entry to and departure from each foreign country through which the hazardous secondary material will pass;

vi) A description of the means by which each shipment of the hazardous secondary material will be transported (e.g., mode of transportation vehicle (air, highway, rail, water, etc.), and the types of container (drums, boxes, tanks, etc.));

vii) A description of the manner in which the hazardous secondary material will be reclaimed in the receiving country;

viii) The name and address of each reclaimer, any intermediate facility, and any alternative reclaimer and intermediate facilities; and

ix) The name of any transit countries through which the hazardous secondary material will be sent, together with a description of the approximate length of time the material will remain in each transit country and the nature of the handling of the material while in the country (for purposes of this Section, the meanings of the terms "Acknowledgement of Consent," "receiving country," and "transit country" are as defined in 35 Ill. Adm. Code 722.151, with the exception that the terms in this Section refer to hazardous secondary materials, rather than hazardous waste).

B) Submission of notification of intent to export hazardous secondary material. Whether delivered by mail or hand delivery, the following words must prominently appear on the front of the envelope: "Attention: Notification of Intent to Export."

i) A notification that is submitted by mail must be sent to the following mailing addresses:

Office of Enforcement and Compliance Assurance
Office of Federal Activities
International Compliance Assurance Division (Mail Code 2254A)
Environmental Protection Agency
1200 Pennsylvania Ave., NW.
Washington, DC 20460

Permits Section
Division of Land Pollution Control
Illinois Environmental Protection Agency
P.O. Box 19276
Springfield, Illinois 62794-9276

ii) A notification that is hand-delivered must be delivered to the following addresses:

Office of Enforcement and Compliance Assurance
Office of Federal Activities
International Compliance Assurance Division
Environmental Protection Agency
Ariel Rios Bldg., Room 6144
12th St. and Pennsylvania Ave., NW.
Washington, DC 20004

Permits Section
Division of Land Pollution Control
Illinois Environmental Protection Agency
1021 North Grand Avenue East
Springfield, Illinois 62794-9276

C) Except for a change in the telephone number submitted pursuant to subsection (a)(25)(A)(i) of this Section or a decrease in the quantity of hazardous secondary material indicated pursuant to subsection (a)(25)(A)(iv) of this Section, when the conditions specified on the original notification change (including any exceedance of the estimate of the quantity of hazardous secondary material specified in the original notification), the hazardous secondary material generator must provide the Agency and USEPA with a written re-notification of the change. The shipment cannot take place until consent of the receiving country to the changes (except for changes to subsection (a)(25)(A)(ix) of this Section and in the ports of entry to and departure from transit countries pursuant to subsection (a)(25)(A)(v) of this Section) has been obtained and the hazardous secondary material generator receives from USEPA an Acknowledgment of Consent reflecting the receiving country's consent to the changes.

D) Upon request from the Agency or USEPA, the hazardous secondary material generator must furnish to the Agency and USEPA any additional information that a receiving country requests in order to respond to a notification.

E) USEPA has stated in corresponding 40 CFR 261.4(a)(25)(v) that it will provide a complete notification to the receiving country and any transit countries. A notification is complete when USEPA determines that the notification satisfies the requirements of subsection (a)(25)(A) of this Section. When a claim of confidentiality is asserted with respect to any notification information required by subsection (a)(25)(A) of this Section, USEPA has stated in corresponding 40 CFR 261.4(a)(25)(v) that it may find the notification not complete until any such claim is resolved in accordance with 40 CFR 260.2.

F) The export of hazardous secondary material pursuant to this subsection (a)(25) is prohibited, unless the receiving country consents to the intended export. When the receiving country consents in writing to the receipt of the hazardous secondary material, USEPA has stated in corresponding 40 CFR 261.4(a)(25)(vi) that it will send an Acknowledgment of Consent to the hazardous secondary material generator. When the receiving country objects to receipt of the hazardous secondary material or withdraws a prior consent, USEPA has stated that it will notify the hazardous secondary material generator in writing. USEPA has stated that it will also notify the hazardous secondary material generator of any responses from transit countries.

G) For exports to OECD Member countries, the receiving country may respond to the notification using tacit consent. If no objection has been lodged by any receiving country or transit countries to a notification provided pursuant to subsection (a)(25)(A) of this Section within 30 days after the date of issuance of the acknowledgement of receipt of notification by the competent authority of the receiving country, the trans-boundary movement may commence. In such cases, USEPA has stated in corresponding 40 CFR 261.4(a)(25)(vii) that it will send an Acknowledgment of Consent to inform the hazardous secondary material generator that the receiving country and any relevant transit countries have not objected to the shipment, and are thus presumed to have consented tacitly. Tacit consent expires one calendar year after the close of the 30-day period; re-notification and renewal of all consents is required for exports after that date.

H) A copy of the Acknowledgment of Consent must accompany the shipment. The shipment must conform to the terms of the Acknowledgment of Consent.

I) If a shipment cannot be delivered for any reason to the reclaimer, intermediate facility or the alternate reclaimer or alternate intermediate facility, the hazardous secondary material generator must re-notify the Agency and USEPA of a change in the conditions of the original notification to allow shipment to a new reclaimer in accordance with subsection (a)(25)(C) of this Section and obtain another Acknowledgment of Consent.

J) The hazardous secondary material generator must keep a copy of each notification of intent to export and each Acknowledgment of Consent for a period of three years following receipt of the Acknowledgment of Consent.

K) Annual reporting of hazardous secondary material exports. A hazardous secondary material generator must file with the Agency and USEPA, no later than March 1 of each year, a report that summarizes the types, quantities, frequency, and ultimate destinations of all hazardous secondary materials exported during the previous calendar year. Annual reports must be sent to the addresses listed in subsection (a)(25)(B) of this Section (for mail or hand delivery, as appropriate) for submission notification of intent to export hazardous secondary material. The annual reports must include the following information:

i) The name, mailing and site addresses, and USEPA identification number (if applicable) of the hazardous secondary material generator;

ii) The calendar year covered by the report;

iii) The name and site address of each reclaimer and intermediate facility that received exported hazardous secondary material from the generator;

iv) By reclaimer and intermediate facility, for each hazardous secondary material exported, a description of the hazardous secondary material and the USEPA hazardous waste number that would apply were the hazardous secondary material to be managed as hazardous waste; the USDOT hazard class for the material, as determined pursuant to 49 CFR 171 through 173, each incorporated by reference in 35 Ill. Adm. Code 720.111; the name and USEPA identification number (where applicable) for each transporter used; the total amount of hazardous secondary material shipped; and the number of shipments pursuant to each notification;

v) A certification signed by the hazardous secondary material generator that states as follows:

"I certify under penalty of law that I have personally examined and am familiar with the information submitted in this and all attached documents, and that, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment."

L) Any person that claims an exclusion under this subsection (a)(25) must provide notification as required by 35 Ill. Adm. Code 720.142.

26) Solvent-contaminated wipes that are sent for cleaning and reuse are not solid wastes from the point of generation, provided that all of the following conditions are fulfilled:

A) The solvent-contaminated wipes, when accumulated, stored, and transported, are contained in non-leaking, closed containers that are labeled "Excluded Solvent-Contaminated Wipes". The containers must be able to contain free liquids, should free liquids

occur. During accumulation, a container is considered closed when there is complete contact between the fitted lid and the rim, except when it is necessary to add or remove solvent-contaminated wipes. When the container is full, when the solvent-contaminated wipes are no longer being accumulated, or when the container is being transported, the container must be sealed with all lids properly and securely affixed to the container and all openings tightly bound or closed sufficiently to prevent leaks and emissions;

B) The solvent-contaminated wipes may be accumulated by the generator for up to 180 days from the start date of accumulation for each container prior to being sent for cleaning;

C) At the point of being sent for cleaning on-site or at the point of being transported off-site for cleaning, the solvent-contaminated wipes must contain no free liquids, as defined in 35 Ill. Adm. Code 720.110;

D) Free liquids removed from the solvent-contaminated wipes or from the container holding the wipes must be managed according to the applicable regulations found in this Part and 35 Ill. Adm. Code 720, 722 through 728, and 733;

E) Generators must maintain at their site the following documentation:

i) The name and address of the laundry or dry cleaner that is receiving the solvent-contaminated wipes;

ii) The documentation that the 180-day accumulation time limit in 35 Ill. Adm. Code 721.104(a)(26)(B) is being met; and

iii) A description of the process the generator is using to ensure that the solvent-contaminated wipes contain no free liquids at the point of being laundered or dry cleaned on-site or at the point of being transported off-site for laundering or dry cleaning; and

F) The solvent-contaminated wipes are sent to a laundry or dry cleaner whose discharge, if any, is regulated under sections 301 and 402 or section 307 of the federal Clean Water Act (33 USC 1311 and 1341 or 33 USC 1317) or equivalent Illinois or sister-state requirements approved by USEPA pursuant to 33 USC 1311 through 1346 and 1370.

b) Solid wastes that are not hazardous wastes. The following solid wastes are not hazardous wastes:

1) Household waste, including household waste that has been collected, transported, stored, treated, disposed of, recovered (e.g., refuse-derived fuel), or reused. "Household waste" means any waste material (including garbage, trash, and sanitary wastes in septic tanks) derived from households (including single and multiple residences, hotels, and motels, bunkhouses, ranger stations, crew quarters, campgrounds, picnic grounds, and day-use recreation areas). A resource recovery facility managing municipal solid waste must not be deemed to be treating, storing, disposing of, or otherwise managing hazardous wastes for the purposes of regulation under this Part, if the following describe the facility:

A) The facility receives and burns only the following waste:

i) Household waste (from single and multiple dwellings, hotels, motels, and other residential sources); or

ii) Solid waste from commercial or industrial sources that does not contain hazardous waste; and

B) The facility does not accept hazardous waste and the owner or operator of such facility has established contractual requirements or other appropriate notification or inspection procedures to assure that hazardous wastes are not received at or burned in such facility.

BOARD NOTE: The U.S. Supreme Court determined, in City of Chicago v. Environmental Defense Fund, Inc., 511 U.S. 328, 114 S. Ct. 1588, 128 L. Ed. 2d 302 (1994), that this exclusion and RCRA section 3001(i) (42 USC 6921(i)) do not exclude the ash from facilities covered by this subsection (b)(1) from regulation as

a hazardous waste. At 59 Fed. Reg. 29372 (June 7, 1994), USEPA granted facilities managing ash from such facilities that is determined a hazardous waste under Subpart C of this Part until December 7, 1994 to file a Part A permit application pursuant to 35 Ill. Adm. Code 703.181. At 60 Fed. Reg. 6666 (Feb. 3, 1995), USEPA stated that it interpreted that the point at which ash becomes subject to RCRA Subtitle C regulation is when that material leaves the combustion building (including connected air pollution control equipment).

2) Solid wastes generated by any of the following that are returned to the soil as fertilizers:

A) The growing and harvesting of agricultural crops, or

B) The raising of animals, including animal manures.

3) Mining overburden returned to the mine site.

4) Fly ash waste, bottom ash waste, slag waste, and flue gas emission control waste generated primarily from the combustion of coal or other fossil fuels, except as provided in 35 Ill. Adm. Code 726.212 for facilities that burn or process hazardous waste.

5) Drilling fluids, produced waters, and other wastes associated with the exploration, development, or production of crude oil, natural gas, or geothermal energy.

6) Chromium wastes.

A) Wastes that fail the test for the toxicity characteristic (Section 721.124 and Appendix B to this Part) because chromium is present or which are listed in Subpart D of this Part due to the presence of chromium, that do not fail the test for the toxicity characteristic for any other constituent or which are not listed due to the presence of any other constituent, and that do not fail the test for any other characteristic, if the waste generator shows the following:

i) The chromium in the waste is exclusively (or nearly

exclusively) trivalent chromium;

ii) The waste is generated from an industrial process that uses trivalent chromium exclusively (or nearly exclusively) and the process does not generate hexavalent chromium; and

iii) The waste is typically and frequently managed in non-oxidizing environments.

B) The following are specific wastes that meet the standard in subsection (b)(6)(A) of this Section (so long as they do not fail the test for the toxicity characteristic for any other constituent and do not exhibit any other characteristic):

i) Chrome (blue) trimmings generated by the following subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, retan/wet finish, no beamhouse, through-the-blue, and shearling;

ii) Chrome (blue) shavings generated by the following subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, retan/wet finish, no beamhouse, through-the-blue, and shearling;

iii) Buffing dust generated by the following subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, retan/wet finish, no beamhouse, through-the-blue;

iv) Sewer screenings generated by the following subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, retan/wet finish, no beamhouse, through-the-blue, and shearling;

v) Wastewater treatment sludges generated by the following

subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, retan/wet finish, no beamhouse, through-the-blue, and shearling;

vi) Wastewater treatment sludges generated by the following subcategories of the leather tanning and finishing industry: hair pulp/chrome tan/retan/wet finish, hair save/chrome tan/retan/wet finish, and through-the-blue;

vii) Waste scrap leather from the leather tanning industry, the shoe manufacturing industry, and other leather product manufacturing industries; and

viii) Wastewater treatment sludges from the production of titanium dioxide pigment using chromium-bearing ores by the chloride process.

7) Solid waste from the extraction, beneficiation, and processing of ores and minerals (including coal, phosphate rock, and overburden from the mining of uranium ore), except as provided by 35 Ill. Adm. Code 726.212 for facilities that burn or process hazardous waste.

A) For purposes of this subsection (b)(7), beneficiation of ores and minerals is restricted to the following activities: crushing; grinding; washing; dissolution; crystallization; filtration; sorting; sizing; drying; sintering; pelletizing; briquetting; calcining to remove water or carbon dioxide; roasting; autoclaving or chlorination in preparation for leaching (except where the roasting (or autoclaving or chlorination) and leaching sequence produces a final or intermediate product that does not undergo further beneficiation or processing); gravity concentration; magnetic separation; electrostatic separation; floatation; ion exchange; solvent extraction; electrowinning; precipitation; amalgamation; and heap, dump, vat tank, and in situ leaching.

B) For the purposes of this subsection (b)(7), solid waste from the processing of ores and minerals includes only the following wastes as generated:

i) Slag from primary copper processing;

ii) Slag from primary lead processing;

iii) Red and brown muds from bauxite refining;

iv) Phosphogypsum from phosphoric acid production;

v) Slag from elemental phosphorus production;

vi) Gasifier ash from coal gasification;

vii) Process wastewater from coal gasification;

viii) Calcium sulfate wastewater treatment plant sludge from primary copper processing;

ix) Slag tailings from primary copper processing;

x) Fluorogypsum from hydrofluoric acid production;

xi) Process wastewater from hydrofluoric acid production;

xii) Air pollution control dust or sludge from iron blast furnaces;

xiii) Iron blast furnace slag;

xiv) Treated residue from roasting and leaching of chrome ore;

xv) Process wastewater from primary magnesium processing by the anhydrous process;

xvi) Process wastewater from phosphoric acid production;

xvii) Basic oxygen furnace and open hearth furnace air pollution control dust or sludge from carbon steel production;

xviii) Basic oxygen furnace and open hearth furnace slag from carbon steel production;

xix) Chloride processing waste solids from titanium tetrachloride production; and

xx) Slag from primary zinc production.

C) A residue derived from co-processing mineral processing secondary materials with normal beneficiation raw materials or with normal mineral processing raw materials remains excluded under this subsection (b) if the following conditions are fulfilled:

i) The owner or operator processes at least 50 percent by weight normal beneficiation raw materials or normal mineral processing raw materials; and

ii) The owner or operator legitimately reclaims the secondary mineral processing materials.

8) Cement kiln dust waste, except as provided by 35 Ill. Adm. Code 726.212 for facilities that burn or process hazardous waste.

9) Solid waste that consists of discarded arsenical-treated wood or wood products that fails the test for the toxicity characteristic for hazardous waste codes D004 through D017 and which is not a hazardous waste for any other reason if the waste is generated by persons that utilize the arsenical-treated wood and wood products for these materials' intended end use.

10) Petroleum-contaminated media and debris that fail the test for the toxicity characteristic of Section 721.124 (hazardous waste codes D018 through D043 only) and which are subject to corrective action regulations under 35 Ill. Adm. Code 731.

11) This subsection (b)(11) corresponds with 40 CFR 261.4(b)(11), which expired by its own terms on January 25, 1993. This statement maintains structural parity with USEPA regulations.

12) Used chlorofluorocarbon refrigerants from totally enclosed heat transfer equipment, including mobile air conditioning systems, mobile refrigeration, and commercial and industrial air conditioning and refrigeration systems, that use chlorofluorocarbons as the heat transfer fluid in a refrigeration cycle, provided the refrigerant is reclaimed for further use.

13) Non-terne plated used oil filters that are not mixed with wastes listed in Subpart D of this Part, if these oil filters have been gravity hot-drained using one of the following methods:

A) Puncturing the filter anti-drain back valve or the filter dome end and hot-draining;

B) Hot-draining and crushing;

C) Dismantling and hot-draining; or

D) Any other equivalent hot-draining method that will remove used oil.

14) Used oil re-refining distillation bottoms that are used as feedstock to manufacture asphalt products.

15) Leachate or gas condensate collected from landfills where certain solid wastes have been disposed of, under the following circumstances:

A) The following conditions must be fulfilled:

i) The solid wastes disposed of would meet one or more of the listing descriptions for the following USEPA hazardous waste numbers that are generated after the effective date listed for the waste:

USEPA Hazardous Waste Numbers	Listing Effective Date
K169, K170, K171, and K172	February 8, 1999

K174 and K175	May 7, 2001
K176, K177, and K178	May 20, 2002
K181	August 23, 2005

ii) The solid wastes described in subsection (b)(15)(A)(i) of this Section were disposed of prior to the effective date of the listing (as set forth in that subsection);

iii) The leachate or gas condensate does not exhibit any characteristic of hazardous waste nor is derived from any other listed hazardous waste; and

iv) Discharge of the leachate or gas condensate, including leachate or gas condensate transferred from the landfill to a POTW by truck, rail, or dedicated pipe, is subject to regulation under section 307(b) or 402 of the federal Clean Water Act (33 USC 1317(b) or 1342).

B) Leachate or gas condensate derived from K169, K170, K171, K172, K176, K177, ~~or~~ K178, or K181 waste will no longer be exempt if it is stored or managed in a surface impoundment prior to discharge. ~~After February 26, 2007, leachate or gas condensate derived from K181 waste will no longer be exempt if it is stored or managed in a surface impoundment prior to discharge.~~ There is one exception: if the surface impoundment is used to temporarily store leachate or gas condensate in response to an emergency situation (e.g., shutdown of wastewater treatment system), provided the impoundment has a double liner, and provided the leachate or gas condensate is removed from the impoundment and continues to be managed in compliance with the conditions of this subsection (b)(15) after the emergency ends.

16) This subsection (b)(16) corresponds with 40 CFR 261.4(b)(16), which USEPA has marked "reserved". This statement maintains structural parity with USEPA regulations.

17) This subsection (b)(17) corresponds with 40 CFR 261.4(b)(17), which pertains exclusively to waste generated by a specific facility outside

Illinois. This statement maintains structural parity with USEPA regulations.

18) Solvent-contaminated wipes, except for wipes that are hazardous waste due to the presence of trichloroethylene, that are sent for disposal are not hazardous wastes from the point of generation provided that all of the following conditions are fulfilled:

A) The solvent-contaminated wipes, when accumulated, stored, and transported, are contained in non-leaking, closed containers that are labeled "Excluded Solvent-Contaminated Wipes". The containers must be able to contain free liquids, should free liquids occur. During accumulation, a container is considered closed when there is complete contact between the fitted lid and the rim, except when it is necessary to add or remove solvent-contaminated wipes. When the container is full, when the solvent-contaminated wipes are no longer being accumulated, or when the container is being transported, the container must be sealed with all lids properly and securely affixed to the container and all openings tightly bound or closed sufficiently to prevent leaks and emissions;

B) The solvent-contaminated wipes may be accumulated by the generator for up to 180 days from the start date of accumulation for each container prior to being sent for disposal;

C) At the point of being transported for disposal, the solvent-contaminated wipes must contain no free liquids, as defined in 35 Ill. Adm. Code 720.110;

D) Free liquids removed from the solvent-contaminated wipes or from the container holding the wipes must be managed according to the applicable regulations found in this Part and 35 Ill. Adm. Code 720, 722 through 728, and 733;

E) Generators must maintain at their site the following documentation:

i) The name and address of the landfill or combustor that is receiving the solvent-contaminated wipes;

ii) The documentation that the 180 day accumulation time limit in 35 Ill. Adm. Code 721.104(b)(18)(B) is being met; and

iii) A description of the process the generator is using to ensure that the solvent-contaminated wipes contain no free liquids at the point of being transported for disposal; and

F) The solvent-contaminated wipes are sent for disposal at one of the following facilities:

i) A municipal solid waste landfill regulated under RCRA Subtitle D regulations: 35 Ill. Adm. Code 810 through 815, including the landfill design criteria of 35 Ill. Adm. Code 811.303 through 811.309, 811.315 through 811.317, and Subpart E of 35 Ill. Adm. Code 811 or 35 Ill. Adm. Code 814.302 and 814.402; 40 CFR 258, including the landfill design criteria of 40 CFR 258.40; or equivalent regulations of a sister state that USEPA has approved pursuant to 42 USC 6943 and 6947; or

ii) A hazardous waste landfill regulated under RCRA Subtitle C regulations: 35 Ill. Adm. Code 724 or 725; 40 CFR 264 or 265; or equivalent regulations of a sister state that USEPA has approved pursuant to 42 USC 6926; or

iii) A municipal waste combustor or other combustion facility regulated under section 129 of the Clean Air Act (42 USC 7429) or equivalent Illinois or sister-state regulations approved by USEPA pursuant to 42 USC 7429; or

iv) A hazardous waste combustor, boiler or industrial furnace regulated under RCRA Subtitle C regulations: 35 Ill. Adm. Code 724 or 725 or 40 subpart H of 726; 40 CFR 264 or 265 or subpart H of 40 CFR 266; or equivalent regulations of a sister state that USEPA has approved pursuant to 42 USC 6926.

c) Hazardous wastes that are exempted from certain regulations. A hazardous waste that is generated in a product or raw material storage tank, a product or raw material transport vehicle or vessel, a product or raw material pipeline, or in a manufacturing process unit, or an associated non-waste-treatment manufacturing unit, is not subject to regulation under 35 Ill. Adm. Code 702, 703, and 722 through 728 or to the notification requirements of section 3010 of RCRA (42 USC 6930) until it exits the unit in which it was generated, unless the unit is a surface impoundment, or unless the hazardous waste remains in the unit more than 90 days after the unit ceases to be operated for manufacturing or for storage or transportation of product or raw materials.

d) Samples.

1) Except as provided in subsection (d)(2) of this Section, a sample of solid waste or a sample of water, soil, or air that is collected for the sole purpose of testing to determine its characteristics or composition is not subject to any requirements of this Part or 35 Ill. Adm. Code 702, 703, and 722 through 728. The sample qualifies when it fulfills one of the following conditions:

A) The sample is being transported to a laboratory for the purpose of testing;

B) The sample is being transported back to the sample collector after testing;

C) The sample is being stored by the sample collector before transport to a laboratory for testing;

D) The sample is being stored in a laboratory before testing;

E) The sample is being stored in a laboratory for testing but before it is returned to the sample collector; or

F) The sample is being stored temporarily in the laboratory after testing for a specific purpose (for example, until conclusion of a court case or enforcement action where further testing of the sample may be necessary).

2) In order to qualify for the exemption in subsection (d)(1)(A) or (d)(1)(B) of this Section, a sample collector shipping samples to a laboratory and a laboratory returning samples to a sample collector must do the following:

A) Comply with USDOT, U.S. Postal Service (USPS), or any other applicable shipping requirements; or

B) Comply with the following requirements if the sample collector determines that USDOT, USPS, or other shipping requirements do not apply to the shipment of the sample:

i) Assure that the following information accompanies the sample: The sample collector's name, mailing address, and telephone number; the laboratory's name, mailing address, and telephone number; the quantity of the sample; the date of the shipment; and a description of the sample; and

ii) Package the sample so that it does not leak, spill, or vaporize from its packaging.

3) This exemption does not apply if the laboratory determines that the waste is hazardous but the laboratory is no longer meeting any of the conditions stated in subsection (d)(1) of this Section.

e) Treatability study samples.

1) Except as is provided in subsection (e)(2) of this Section, a person that generates or collects samples for the purpose of conducting treatability studies, as defined in 35 Ill. Adm. Code 720.110, are not subject to any requirement of 35 Ill. Adm. Code 721 through 723 or to the notification requirements of section 3010 of the Resource Conservation and Recovery Act. Nor are such samples included in the quantity determinations of Section 721.105 and 35 Ill. Adm. Code 722.134(d) when:

A) The sample is being collected and prepared for transportation by the generator or sample collector;

B) The sample is being accumulated or stored by the generator or sample collector prior to transportation to a laboratory or testing

facility; or

C) The sample is being transported to the laboratory or testing facility for the purpose of conducting a treatability study.

2) The exemption in subsection (e)(1) of this Section is applicable to samples of hazardous waste being collected and shipped for the purpose of conducting treatability studies provided that the following conditions are fulfilled:

A) The generator or sample collector uses (in "treatability studies") no more than 10,000 kg of media contaminated with non-acute hazardous waste, 1,000 kg of non-acute hazardous waste other than contaminated media, 1 kg of acute hazardous waste, or 2,500 kg of media contaminated with acute hazardous waste for each process being evaluated for each generated waste stream;

B) The mass of each shipment does not exceed 10,000 kg; the 10,000 kg quantity may be all media contaminated with non-acute hazardous waste, or may include 2,500 kg of media contaminated with acute hazardous waste, 1,000 kg of hazardous waste, and 1 kg of acute hazardous waste;

C) The sample must be packaged so that it does not leak, spill, or vaporize from its packaging during shipment and the requirements of subsection (e)(2)(C)(i) or (e)(2)(C)(ii) of this Section are met.

i) The transportation of each sample shipment complies with USDOT, USPS, or any other applicable shipping requirements; or

ii) If the USDOT, USPS, or other shipping requirements do not apply to the shipment of the sample, the following information must accompany the sample: The name, mailing address, and telephone number of the originator of the sample; the name, address, and telephone number of the facility that will perform the treatability study; the quantity of the sample; the date of the shipment; and, a description of the sample, including its USEPA hazardous waste

number;

D) The sample is shipped to a laboratory or testing facility that is exempt under subsection (f) of this Section, or has an appropriate RCRA permit or interim status;

E) The generator or sample collector maintains the following records for a period ending three years after completion of the treatability study:

i) Copies of the shipping documents;

ii) A copy of the contract with the facility conducting the treatability study; and

iii) Documentation showing the following: The amount of waste shipped under this exemption; the name, address, and USEPA identification number of the laboratory or testing facility that received the waste; the date the shipment was made; and whether or not unused samples and residues were returned to the generator; and

F) The generator reports the information required in subsection (e)(2)(E)(iii) of this Section in its report under 35 Ill. Adm. Code 722.141.

3) The Agency may grant requests on a case-by-case basis for up to an additional two years for treatability studies involving bioremediation. The Agency may grant requests, on a case-by-case basis, for quantity limits in excess of those specified in subsections (e)(2)(A), (e)(2)(B), and (f)(4) of this Section, for up to an additional 5,000 kg of media contaminated with non-acute hazardous waste, 500 kg of non-acute hazardous waste, 2,500 kg of media contaminated with acute hazardous waste, and 1 kg of acute hazardous waste under the circumstances set forth in either subsection (e)(3)(A) or (e)(3)(B) of this Section, subject to the limitations of subsection (e)(3)(C) of this Section:

A) In response to requests for authorization to ship, store, and conduct further treatability studies on additional quantities in advance of

commencing treatability studies. Factors to be considered in reviewing such requests include the nature of the technology, the type of process (e.g., batch versus continuous), the size of the unit undergoing testing (particularly in relation to scale-up considerations), the time or quantity of material required to reach steady-state operating conditions, or test design considerations, such as mass balance calculations.

B) In response to requests for authorization to ship, store, and conduct treatability studies on additional quantities after initiation or completion of initial treatability studies when the following occurs: There has been an equipment or mechanical failure during the conduct of the treatability study, there is need to verify the results of a previously-conducted treatability study, there is a need to study and analyze alternative techniques within a previously-evaluated treatment process, or there is a need to do further evaluation of an ongoing treatability study to determine final specifications for treatment.

C) The additional quantities allowed and timeframes allowed in subsections (e)(3)(A) and (e)(3)(B) of this Section are subject to all the provisions in subsections (e)(1) and (e)(2)(B) through (e)(2)(F) of this Section. The generator or sample collector must apply to the Agency and provide in writing the following information:

i) The reason why the generator or sample collector requires additional time or quantity of sample for the treatability study evaluation and the additional time or quantity needed;

ii) Documentation accounting for all samples of hazardous waste from the waste stream that have been sent for or undergone treatability studies, including the date each previous sample from the waste stream was shipped, the quantity of each previous shipment, the laboratory or testing facility to which it was shipped, what treatability study processes were conducted on each sample shipped, and the available results of each treatability study;

iii) A description of the technical modifications or change in

specifications that will be evaluated and the expected results;

iv) If such further study is being required due to equipment or mechanical failure, the applicant must include information regarding the reason for the failure or breakdown and also include what procedures or equipment improvements have been made to protect against further breakdowns; and

v) Such other information as the Agency determines is necessary.

4) Final Agency determinations pursuant to this subsection (e) may be appealed to the Board.

f) Samples undergoing treatability studies at laboratories or testing facilities. Samples undergoing treatability studies and the laboratory or testing facility conducting such treatability studies (to the extent such facilities are not otherwise subject to RCRA requirements) are not subject to any requirement of this Part, or of 35 Ill. Adm. Code 702, 703, 722 through 726, and 728 or to the notification requirements of Section 3010 of the Resource Conservation and Recovery Act (42 USC 6930), provided that the requirements of subsections (f)(1) through (f)(11) of this Section are met. A mobile treatment unit may qualify as a testing facility subject to subsections (f)(1) through (f)(11) of this Section. Where a group of mobile treatment units are located at the same site, the limitations specified in subsections (f)(1) through (f)(11) of this Section apply to the entire group of mobile treatment units collectively as if the group were one mobile treatment unit.

1) No less than 45 days before conducting treatability studies, the facility notifies the Agency in writing that it intends to conduct treatability studies under this subsection (f).

2) The laboratory or testing facility conducting the treatability study has a USEPA identification number.

3) No more than a total of 10,000 kg of "as received" media contaminated with non-acute hazardous waste, 2,500 kg of media contaminated with acute hazardous waste, or 250 kg of other "as received" hazardous waste is subject to initiation of treatment in all treatability studies in any single

day. "As received" waste refers to the waste as received in the shipment from the generator or sample collector.

4) The quantity of "as received" hazardous waste stored at the facility for the purpose of evaluation in treatability studies does not exceed 10,000 kg, the total of which can include 10,000 kg of media contaminated with non-acute hazardous waste, 2,500 kg of media contaminated with acute hazardous waste, 1,000 kg of non-acute hazardous wastes other than contaminated media, and 1 kg of acute hazardous waste. This quantity limitation does not include treatment materials (including non-hazardous solid waste) added to "as received" hazardous waste.

5) No more than 90 days have elapsed since the treatability study for the sample was completed, or no more than one year (two years for treatability studies involving bioremediation) has elapsed since the generator or sample collector shipped the sample to the laboratory or testing facility, whichever date first occurs. Up to 500 kg of treated material from a particular waste stream from treatability studies may be archived for future evaluation up to five years from the date of initial receipt. Quantities of materials archived are counted against the total storage limit for the facility.

6) The treatability study does not involve the placement of hazardous waste on the land or open burning of hazardous waste.

7) The facility maintains records for three years following completion of each study that show compliance with the treatment rate limits and the storage time and quantity limits. The following specific information must be included for each treatability study conducted:

A) The name, address, and USEPA identification number of the generator or sample collector of each waste sample;

B) The date the shipment was received;

C) The quantity of waste accepted;

D) The quantity of "as received" waste in storage each day;

E) The date the treatment study was initiated and the amount of "as received" waste introduced to treatment each day;

F) The date the treatability study was concluded;

G) The date any unused sample or residues generated from the treatability study were returned to the generator or sample collector or, if sent to a designated facility, the name of the facility and the USEPA identification number.

8) The facility keeps, on-site, a copy of the treatability study contract and all shipping papers associated with the transport of treatability study samples to and from the facility for a period ending three years from the completion date of each treatability study.

9) The facility prepares and submits a report to the Agency, by March 15 of each year, that includes the following information for the previous calendar year:

A) The name, address, and USEPA identification number of the facility conducting the treatability studies;

B) The types (by process) of treatability studies conducted;

C) The names and addresses of persons for whom studies have been conducted (including their USEPA identification numbers);

D) The total quantity of waste in storage each day;

E) The quantity and types of waste subjected to treatability studies;

F) When each treatability study was conducted; and

G) The final disposition of residues and unused sample from each treatability study.

10) The facility determines whether any unused sample or residues generated by the treatability study are hazardous waste under Section 721.103 and, if so, are subject to 35 Ill. Adm. Code 702, 703, and 721 through 728, unless

the residues and unused samples are returned to the sample originator under the exemption of subsection (e) of this Section.

11) The facility notifies the Agency by letter when the facility is no longer planning to conduct any treatability studies at the site.

g) Dredged material that is not a hazardous waste. Dredged material that is subject to the requirements of a permit that has been issued under section 404 of the Federal Water Pollution Control Act (33 USC 1344) is not a hazardous waste. For the purposes of this subsection (g), the following definitions apply:

"Dredged material" has the meaning ascribed it in 40 CFR 232.2 (Definitions), incorporated by reference in 35 Ill. Adm. Code 720.111(b).

"Permit" means any of the following:

A permit issued by the U.S. Army Corps of Engineers (Army Corps) under section 404 of the Federal Water Pollution Control Act (33 USC 1344);

A permit issued by the Army Corps under section 103 of the Marine Protection, Research, and Sanctuaries Act of 1972 (33 USC 1413); or

In the case of Army Corps civil works projects, the administrative equivalent of the permits referred to in the preceding two paragraphs of this definition, as provided for in Army Corps regulations (for example, see 33 CFR 336.1, 336.2, and 337.6).

h) Carbon dioxide stream injected for geologic sequestration. Carbon dioxide streams that are captured and transported for purposes of injection into an underground injection well subject to the requirements for Class VI carbon sequestration injection wells, including the requirements in 35 Ill. Adm. Code 704 and 730, are not a hazardous waste, provided the following conditions are met:

1) Transportation of the carbon dioxide stream must be in compliance with U.S. Department of Transportation requirements, including the pipeline safety laws (chapter 601 of subtitle VIII of 49 USC, incorporated by reference in 35 Ill. Adm. Code 720.111) and regulations (49 CFR 190

through 199, incorporated by reference in 35 Ill. Adm. Code 720.111) of the U.S. Department of Transportation, and pipeline safety regulations adopted and administered by a state authority pursuant to a certification under 49 USC 60105, incorporated by reference in 35 Ill. Adm. Code 720.111, and 49 CFR 171 through 180, incorporated by reference in 35 Ill. Adm. Code 720.111, as applicable.

BOARD NOTE: The parenthetical language relating to pipeline transportation does not preclude transportation by air, water, highway or rail that complies with U.S. Department of Transportation regulations at 49 CFR 171 through 180. For this reason, the Board has added citations of those regulations.

2) Injection of the carbon dioxide stream must be in compliance with the applicable requirements for Class VI carbon sequestration injection wells, including the applicable requirements in 35 Ill. Adm. Code 704 and 730;

3) No hazardous wastes shall be mixed with, or otherwise co-injected with, the carbon dioxide stream; and

4) Required Certifications.

A) Any generator of a carbon dioxide stream, who claims that a carbon dioxide stream is excluded under this subsection (h), must have an authorized representative (as defined in 35 Ill. Adm. Code 720.110) sign a certification statement worded as follows:

"I certify under penalty of law that the carbon dioxide stream that I am claiming to be excluded under 35 Ill. Adm. Code 721.104(h) has not been mixed with hazardous wastes, and I have transported the carbon dioxide stream in compliance with (or have contracted with a pipeline operator or transporter to transport the carbon dioxide stream in compliance with) U.S. Department of Transportation requirements, including the pipeline safety laws (49 USC 60101 et seq.) and regulations (49 CFR 190 through 199) of the U.S. Department of Transportation, and the pipeline safety regulations adopted and administered by a state authority pursuant to a certification under 49 USC

60105, as applicable, for injection into a well subject to the requirements for the Class VI Underground Injection Control Program of the federal Safe Drinking Water Act (42 USC 300f et seq.)."

B) Any Class VI carbon sequestration injection well owner or operator, who claims that a carbon dioxide stream is excluded under this subsection (h), must have an authorized representative (as defined in 35 Ill. Adm. Code 720.110) sign a certification statement worded as follows:

"I certify under penalty of law that the carbon dioxide stream that I am claiming to be excluded under 35 Ill. Adm. Code 721.104(h) has not been mixed with, or otherwise co-injected with, hazardous waste at the UIC Class VI permitted facility, and that injection of the carbon dioxide stream is in compliance with the applicable requirements for UIC Class VI wells, including the applicable requirements in 35 Ill. Adm. Code 704 and 730."

C) The signed certification statement must be kept on-site for no less than three years, and must be made available within 72 hours after a written request from the Agency or USEPA, or their designee. The signed certification statement must be renewed every year that the exclusion is claimed, by having an authorized representative (as defined in 35 Ill. Adm. Code 720.110) annually prepare and sign a new copy of the certification statement within one year after the date of the previous statement. The signed certification statement must also be readily accessible on the facility's publicly-available website (if such website exists) as a public notification with the title of "Carbon Dioxide Stream Certification" at the time the exclusion is claimed.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 721.105 Special Requirements for Hazardous Waste Generated by Small Quantity Generators

a) A generator is a conditionally exempt small quantity generator (CESQG) in a

calendar month if it generates no more than 100 kilograms of hazardous waste in that month.

b) Except for those wastes identified in subsections (e), (f), (g), and (j) of this Section, a CESQG's hazardous wastes are not subject to regulation under 35 Ill. Adm. Code 702, 703, and 722 through 728, and the notification requirements of section 3010 of Resource Conservation and Recovery Act (42 USC 6930), provided the generator complies with subsections (f), (g), and (j) of this Section.

c) When making the quantity determinations of this Part and 35 Ill. Adm. Code 722, the generator must include all hazardous waste that it generates, except the following hazardous waste:

1) Hazardous waste that is exempt from regulation under Section 721.104(c) through (f), 721.106(a)(3), 721.107(a)(1), or 721.108;

2) Hazardous waste that is managed immediately upon generation only in on-site elementary neutralization units, wastewater treatment units, or totally enclosed treatment facilities, as defined in 35 Ill. Adm. Code 720.110;

3) Hazardous waste that is recycled, without prior storage or accumulation, only in an on-site process subject to regulation under Section 721.106(c)(2);

4) Hazardous waste that is used oil managed pursuant to Section 721.106(a)(4) and 35 Ill. Adm. Code 739;

5) Hazardous waste that is spent lead-acid batteries managed pursuant to Subpart G of 35 Ill. Adm. Code 726;

6) Hazardous waste that is universal waste managed pursuant to Section 721.109 and 35 Ill. Adm. Code 733; and

7) Hazardous waste that is an unused commercial chemical product (that is listed in Subpart D of 35 Ill. Adm. Code 721 or which exhibits one or more characteristics in Subpart C of 35 Ill. Adm. Code 721) that is generated solely as a result of a laboratory clean-out conducted at an eligible academic entity pursuant to Section 722.313. For purposes of this

subsection (c)(7), the term "eligible academic entity" has the meaning given that term in 35 Ill. Adm. Code 722.300.

d) In determining the quantity of hazardous waste it generates, a generator need not include the following:

1) Hazardous waste when it is removed from on-site storage;

2) Hazardous waste produced by on-site treatment (including reclamation) of its hazardous waste so long as the hazardous waste that is treated was counted once;

3) Spent materials that are generated, reclaimed, and subsequently reused on-site, so long as such spent materials have been counted once.

e) If a generator generates acute hazardous waste in a calendar month in quantities greater than those set forth in subsections (e)(1) and (e)(2) of this Section, all quantities of that acute hazardous waste are subject to full regulation under 35 Ill. Adm. Code 702, 703, and 722 through 728, and the notification requirements of section 3010 of the Resource Conservation and Recovery Act (42 USC 6930).

1) A total of one kilogram of one or more of the acute hazardous wastes listed in Section 721.131 or 721.133(e); or

2) A total of 100 kilograms of any residue or contaminated soil, waste, or other debris resulting from the clean-up of a spill, into or on any land or water, of any one or more of the acute hazardous wastes listed in Section 721.131 or 721.133(e).

BOARD NOTE: "Full regulation" means those regulations applicable to generators of 1,000 kg or greater of hazardous waste in a calendar month.

f) In order for acute hazardous wastes generated by a generator of acute hazardous wastes in quantities equal to or less than those set forth in subsections~~subsections~~ (e)(1) or (e)(2) of this Section to be excluded from full regulation under this Section, the generator must comply with the following requirements:

1) 35 Ill. Adm. Code 722.111.

2) The generator may accumulate acute hazardous waste on-site. If the generator accumulates at any time acute hazardous wastes in quantities greater than set forth in subsection (e)(1) or (e)(2) of this Section, all of those accumulated wastes are subject to regulation under 35 Ill. Adm. Code 702, 703, and 722 through 728, and the applicable notification requirements of section 3010 of the Resource Conservation and Recovery Act. The time period of 35 Ill. Adm. Code 722.134(a), for accumulation of wastes on-site, begins when the accumulated wastes exceed the applicable exclusion limit.

3) A CESQG may either treat or dispose of its acute hazardous waste in an on-site facility or ensure delivery to an off-site treatment, storage, or disposal facility, any of which, if located in the United States, meets any of the following conditions:

A) The facility is permitted under 35 Ill. Adm. Code 702 and 703;

B) The facility has interim status under 35 Ill. Adm. Code 702, 703, and 725;

C) The facility is authorized to manage hazardous waste by a state with a hazardous waste management program approved by USEPA pursuant to 40 CFR 271;

D) The facility is permitted, licensed, or registered by a state to manage municipal solid waste and, if managed in a municipal solid waste landfill facility, the landfill is subject to 35 Ill. Adm. Code 810 through 814 or federal 40 CFR 258;

E) The facility is permitted, licensed, or registered by a state to manage non-municipal non-hazardous waste and, if managed in a non-municipal non-hazardous waste disposal unit, the unit is subject to federal 40 CFR 257.5 through 257.30;

BOARD NOTE: The Illinois non-hazardous waste landfill regulations, 35 Ill. Adm. Code 810 through 814, do not allow the disposal of hazardous waste in a landfill regulated under those rules. The Board intends that subsections (f)(3)(D) and (f)(3)(E) of this Section impose a federal requirement on the hazardous waste

generator. The Board specifically does not intend that these subsections authorize any disposal of conditionally-exempt small quantity generator waste in a landfill not specifically permitted to accept the particular hazardous waste.

F) The facility is one that fulfills one of the following conditions:

i) It beneficially uses or reuses or legitimately recycles or reclaims its waste; or

ii) It treats its waste prior to beneficial use or reuse or legitimate recycling or reclamation; or

G) For universal waste managed under 35 Ill. Adm. Code 733 or federal 40 CFR 273, the facility is a universal waste handler or destination facility subject to 35 Ill. Adm. Code 733 or federal 40 CFR 273.

g) In order for hazardous waste generated by a CESQG in quantities of 100 kilograms or less ~~kilograms~~of hazardous waste during a calendar month to be excluded from full regulation under this Section, the generator must comply with the following requirements:

1) The hazardous waste determination requirements of 35 Ill. Adm. Code 722.111;

2) The CESQG may accumulate hazardous waste on-site. If it accumulates at any time 1,000 kilograms or greater of the generator's hazardous waste, all of those accumulated wastes are subject to regulation pursuant to the special provisions of 35 Ill. Adm. Code 722 applicable to generators of greater than 100 kg and less than 1,000 kg of hazardous waste in a calendar month, as well as 35 Ill. Adm. Code 702, 703, and 723 through 728, and the applicable notification requirements of Section 3010 of the Resource Conservation and Recovery Act (42 USC 6930). The time period of 35 Ill. Adm. Code 722.134(d) for accumulation of wastes on-site begins for a small quantity generator when the accumulated wastes equal or exceed 1,000 kilograms;

3) A CESQG may either treat or dispose of its hazardous waste in an on-site

facility or ensure delivery to an off-site treatment, storage, or disposal facility, any of which, if located in the United States, meets any of the following conditions:

A) The facility is permitted under 35 Ill. Adm. Code 702 and 703;

B) The facility has interim status under 35 Ill. Adm. Code 702, 703, and 725;

C) The facility is authorized to manage hazardous waste by a state with a hazardous waste management program approved by USEPA pursuant to 40 CFR 271;

D) The facility is permitted, licensed, or registered by a state to manage municipal solid waste and, if managed in a municipal solid waste landfill facility, the landfill is subject to 35 Ill. Adm. Code 810 through 814 or federal 40 CFR 258;

E) The facility is permitted, licensed, or registered by a state to manage non-municipal non-hazardous waste and, if managed in a non-municipal non-hazardous waste disposal unit, the unit is subject to federal CESQG waste landfill disposal standards in 40 CFR 257.5 through 257.30;

BOARD NOTE: The Illinois non-hazardous waste landfill regulations, 35 Ill. Adm. Code 810 through 814, do not allow the disposal of hazardous waste in a landfill regulated under those rules. The Board intends that subsections (g)(3)(D) and (g)(3)(E) of this Section impose a federal requirement on the hazardous waste generator. The Board specifically does not intend that these subsections authorize any disposal of conditionally-exempt small quantity generator waste in a landfill not specifically permitted to accept the particular hazardous waste.

F) The facility is one that fulfills the following conditions:

i) It beneficially uses or re-uses, or legitimately recycles or reclaims the small quantity generator's waste; or

ii) It treats its waste prior to beneficial use or re-use or legitimate recycling or reclamation; or

G) For universal waste managed under 35 Ill. Adm. Code 733 or federal 40 CFR 273, the facility is a universal waste handler or destination facility subject to 35 Ill. Adm. Code 733 or federal 40 CFR 273.

h) Hazardous waste subject to the reduced requirements of this Section may be mixed with non-hazardous waste and remain subject to these reduced requirements even though the resultant mixture exceeds the quantity limitations identified in this Section, unless the mixture meets any of the characteristics of hazardous wastes identified in Subpart C of this Part.

i) If a small quantity generator mixes a solid waste with a hazardous waste that exceeds a quantity exclusion level of this Section, the mixture is subject to full regulation.

j) If a CESQG's hazardous wastes are mixed with used oil, the mixture is subject to the used oil standards in 35 Ill. Adm. Code 739. Any material produced from such a mixture by processing, blending, or other treatment is also so regulated.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Newborn Metabolic Screening and Treatment Code

2) Code Citation: 77 Ill. Adm. Code 661

3)

Section Numbers:	Proposed Action:
661.10	Amend
661.15	Amend

4) Statutory Authority: Implementing and authorized by the Newborn Metabolic Screening Act [410 ILCS 240]

5) A Complete Description of the Subjects and Issues Involved: The Department of Public Health Division of Laboratories provides testing to support the Newborn Screening Program. After testing is complete, specimens will be retained for a period of time (at least two months) in case repeat testing or supplemental testing of the specimen is necessary to complete the screening. When this supplemental testing is not performed by the Division of Laboratories, it may be necessary to engage the services of other clinical laboratories to perform this additional testing. Retained specimens are also used to provide quality control material to ensure the accuracy of current methods and those methods under development. If the specimen is determined to be normal, it will be retained for not longer than four months. Since abnormal specimens provide a special opportunity for quality control and are rarely encountered, they will be retained for a longer period of time. Abnormal specimens will be retained for a maximum of six years. After storage by the Division of Laboratories, all specimens will be destroyed.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

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

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

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

9) Does this rulemaking contain incorporation by reference? No

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

11) Statement of Statewide Policy Objective: This rulemaking does not create or expand any State mandates on units of local government.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Written or e-mail comments may be submitted within 45 days after this issue of the *Illinois Register* to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 W. Jefferson St., 5th floor
Springfield IL 62761

217/782-2043
e-mail: dph.rules@illinois.gov

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: This rulemaking did not appear on either of the Department's most recent Regulatory Agendas because the need for the rulemaking was not apparent when the Regulatory Agendas were prepared.

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

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

PART 661
NEWBORN METABOLIC SCREENING AND TREATMENT CODE

Section
661.10 Responsibility for Screening
661.15 Definitions
661.20 Collection of Blood and Submission of Specimens
661.30 Interpretation of Results
661.35 Designation of Medical Specialists
661.40 Reports
661.50 Diagnosis and Treatment
661.60 Exemption
661.70 Fee Assessment and Payment

AUTHORITY: Implementing and authorized by the Newborn Metabolic Screening Act [410 ILCS 240].

SOURCE: Adopted December 14, 1973; emergency rules at 3 Ill. Reg. 28, p. 224, effective June 28, 1979, for a maximum of 150 days; rules repealed and new rules adopted at 3 Ill. Reg. 48, p. 42, effective November 20, 1979; amended at 5 Ill. Reg. 4593, effective April 15, 1981; amended and codified at 8 Ill. Reg. 19041, effective September 26, 1984; amended at 11 Ill. Reg. 12921, effective August 1, 1987; amended at 13 Ill. Reg. 15079, effective October 1, 1989; amended at 14 Ill. Reg. 13292, effective August 15, 1990; amended at 17 Ill. Reg. 13609, effective August 1, 1993; amended at 19 Ill. Reg. 15720, effective November 1, 1995; expedited correction at 20 Ill. Reg. 3590, effective November 1, 1995; amended at 22 Ill. Reg. 20639, effective November 10, 1998; amended at 26 Ill. Reg. 10676, effective July 1, 2002; amended at 26 Ill. Reg. 18412, effective January 1, 2003; amended at 31 Ill. Reg. 13203, effective August 28, 2007; amended at 34 Ill. Reg. 940, effective December 31, 2009; amended at 36 Ill. Reg. 1753, effective January 19, 2012; amended at 37 Ill. Reg. 13452, effective July 31, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 661.10 Responsibility for Screening

a) The physician in attendance at or immediately after the birth of the newborn

infant shall have primary responsibility for seeing that a specimen of the infant's blood is screened in accordance with this Part. Newborn screening includes tests for the following disorders: classical phenylketonuria (PKU) and certain other amino acid, organic acid, and fatty acid oxidation disorders; primary hypothyroidism; classical galactosemia; congenital adrenal hyperplasia due to 21-hydroxylase deficiency; biotinidase deficiency; sickle cell disease/trait; cystic fibrosis; lysosomal storage disorders; and severe combined immunodeficiency. Specific diseases in the categories of amino acid, organic acid, and fatty acid oxidation disorders and lysosomal storage disorders shall be reviewed by the Genetic and Metabolic Diseases Advisory Committee. The Department will consider the recommendations of the Genetic and Metabolic Diseases Advisory Committee in determining to include an additional disorder in the screening panel. Implementation of the Department's determination is subject to that determination's adoption by rule. For a current list of disorders, refer to the Illinois Department of Public Health Newborn Screening Practitioner's Manual. A blood specimen meeting the requirements for testing shall suffice for all tests (see Section 661.20). The physician may delegate this responsibility to the hospital administrator or to the administrator's designated representative, such as a member of the pediatrics staff, the laboratory director, the obstetrical supervisor, or other hospital official.

b) If the infant is not born in or admitted to a hospital or when there is no physician in attendance at or immediately after the birth, the physician caring for the infant during the first month of life shall be the individual responsible for seeing that a blood specimen for newborn screening is submitted. When there is no physician caring for the infant during this period, the parents or guardian is responsible. Local health authorities or the Department will assist the parents or guardian in having a blood specimen submitted for testing.

c) All specimens collected pursuant to this Part shall be submitted for testing to the Newborn Screening Section, Division of Laboratories, Illinois Department of Public Health, 2121 West Taylor Street, Chicago, Illinois 60612 (see Section 661.20).

d) When a retest is determined to be necessary pursuant to Section 661.30 of this Part, the ~~Illinois~~ Department ~~of Public Health~~ will notify the physician or his or her designee who is responsible for obtaining another specimen and having the specimen tested.

e) Specimens received by the Department for newborn screening will be retained for a minimum of two months. If all test results obtained from a specimen are determined to be within normal range, the specimen will be retained for a maximum of four months. If any test result obtained from a specimen is determined to be abnormal (i.e., out of normal range), the specimen will be retained for a maximum of six years. Specimens that the Department retains may be used within the Department for quality control purposes as required under the Clinical Laboratory Improvement Amendments (CLIA). Based on the Department's testing capabilities, specimens with an abnormal result may be referred to other clinical laboratories for supplemental testing to further characterize the abnormality. After the maximum time period for retention, the Department will destroy all specimens.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 661.15 Definitions

"Act" means the Newborn Metabolic Screening Act [410 ILCS 240].

"Advisory Committee" means the Genetic and Metabolic Diseases Advisory Committee appointed by the Director.

"Clinical and Laboratory Standards Institute" or "CLSI" means a global nonprofit standards-developing organization that promotes the development and use of voluntary consensus standards and guidelines within the health care community.

"Clinical Laboratory Improvement Amendments" or "CLIA" means federal regulations (Centers for Medicare and Medicaid Services, United States Department of Health and Human Services) providing standards applicable to all facilities or sites in the United States that test human specimens for health assessment or to diagnose, prevent or treat disease.

"Department" or "DPH" means the Department of Public Health.

"Director" means the Director of the Department of Public Health.

"Formula" means a medically prescribed treatment substance that has been designed to treat a specific metabolic disorder.

"Lysosomal storage disorders" or "LSD" means disorders including, but not limited to, the following: Krabbe, Pompe, Gaucher, Fabry, Niemann-Pick and Mucopolysaccharidosis Type I (Hurlers syndrome) and Mucopolysaccharidosis Type II (Hunters syndrome), which are inherited metabolic disorders caused by lysosomal dysfunction, usually as a consequence of deficiency of a single enzyme required for the metabolism of lipids, glycoproteins or mucopolysaccharides.

"Newborn screening" or "testing" means the testing of a blood sample for classical phenylketonuria (PKU) and certain other amino acid, organic acid, and fatty acid oxidation disorders, primary hypothyroidism, classical galactosemia, congenital adrenal hyperplasia due to 21-hydroxylase deficiency, biotinidase deficiency, sickle cell disease/trait, cystic fibrosis, lysosomal storage disorders, and severe combined immunodeficiency. At times, variant forms of some disorders, or related conditions, may also be identified.

"Quality control" means a procedure or set of procedures to assure the accuracy of results reported by the laboratory.

"Tandem mass spectrometry" or "MS/MS" means use of a tandem mass spectrometer and associated software to test a newborn screening sample.

"Severe combined immunodeficiency and T cell lymphopenia or "SCID" means a primary immune deficiency characterized by a severe defect in both the T and B lymphocyte systems.

"Supplemental test" means any test approved by the United States Food and Drug Administration or validated under a laboratory's CLIA certification that is used to further characterize a newborn screening specimen that had received a positive (i.e., abnormal) result when initially screened by the laboratory.

"Using accepted statistical techniques" means using techniques that have been published in peer reviewed scientific literature.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Income Tax

2) Code Citation: 86 Ill. Adm. Code 100

3) Section Number: 100.2171 Proposed Action: New

4) Statutory Authority: 35 ILCS 5//220.

5) A Complete Description of the Subjects and Issues Involved: This rulemaking provides guidance for taxpayers entitled to the Angel Investment Credit under IITA Section 220 for investments made in qualifying Illinois businesses.

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? Yes

Section Numbers	Proposed Action	*Illinois Register* Citation
100.2110	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2120	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2160	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2185	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2190	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2480	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2655	Amendment	37 Ill. Reg. 15464, September 27, 2013
100.2657	New Section	37 Ill. Reg. 19082, December 2, 2013
100.2060	New Section	38 Ill. Reg. 832, January 10, 2014
100.2198	Amendments	38 Ill. Reg. 3482, February 7, 2014
100.7380	New Section	38 Ill. Reg. 3482, February 7, 2014

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

11) Statement of Statewide Policy Objective: This rulemaking does not create a State mandate, nor does it modify any existing State mandates.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rulemaking may submit them in writing by no later than 45 days after publication of this Notice to:

Illinois Department of Revenue
Paul Caselton
Deputy Counsel Income Tax
Legal Services Office
101 West Jefferson
Springfield IL 62794

217/782-7055

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Small businesses entitled to the Angel Investment Credit and qualifying small businesses that can qualify their investors for the credit will receive guidance on earning and claiming that credit.

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 2014

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

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 100
INCOME TAX

SUBPART A: TAX IMPOSED

Section
100.2000 Introduction
100.2050 Net Income (IITA Section 202)

SUBPART B: CREDITS

Section
100.2100 Replacement Tax Investment Credit Prior to January 1, 1994 (IITA 201(e))
100.2101 Replacement Tax Investment Credit (IITA 201(e))
100.2110 Investment Credit; Enterprise Zone and River Edge Redevelopment Zone (IITA 201(f))
100.2120 Jobs Tax Credit; Enterprise Zone and Foreign Trade Zone or Sub-Zone (IITA 201(g))
100.2130 Investment Credit; High Impact Business (IITA 201(h))
100.2140 Credit Against Income Tax for Replacement Tax (IITA 201(i))
100.2150 Training Expense Credit (IITA 201(j))
100.2160 Research and Development Credit (IITA 201(k))
100.2163 Environmental Remediation Credit (IITA 201(l))
100.2165 Education Expense Credit (IITA 201(m))
100.2170 Tax Credits for Coal Research and Coal Utilization Equipment (IITA 206)
100.2171 Angel Investment Credit (IITA 220)
100.2180 Credit for Residential Real Property Taxes (IITA 208)
100.2185 Film Production Services Credit (IITA 213)
100.2190 Tax Credit for Affordable Housing Donations (IITA Section 214)
100.2193 Student-Assistance Contributions Credit (IITA 218)
100.2195 Dependent Care Assistance Program Tax Credit (IITA 210)
100.2196 Employee Child Care Assistance Program Tax Credit (IITA Section 210.5)
100.2197 Foreign Tax Credit (IITA Section 601(b)(3))
100.2198 Economic Development for a Growing Economy Credit (IITA 211)
100.2199 Illinois Earned Income Tax Credit (IITA Section 212)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

SUBPART C: NET OPERATING LOSSES OF UNITARY BUSINESS GROUPS OCCURRING PRIOR TO DECEMBER 31, 1986

Section
100.2200 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group. (IITA Section 202) − Scope
100.2210 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group (IITA Section 202) − Definitions
100.2220 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group. (IITA Section 202) − Current Net Operating Losses: Offsets Between Members
100.2230 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group. (IITA Section 202) − Carrybacks and Carryforwards
100.2240 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group: (IITA Section 202) − Effect of Combined Net Operating Loss in Computing Illinois Base Income
100.2250 Net Operating Losses Occurring Prior to December 31, 1986, of Unitary Business Groups: Treatment by Members of the Unitary Business Group: (IITA Section 202) − Deadline for Filing Claims Based on Net Operating Losses Carried Back From a Combined Apportionment Year

SUBPART D: ILLINOIS NET LOSS DEDUCTIONS FOR LOSSES OCCURRING ON OR AFTER DECEMBER 31, 1986

Section
100.2300 Illinois Net Loss Deduction for Losses Occurring On or After December 31, 1986 (IITA 207)
100.2310 Computation of the Illinois Net Loss Deduction for Losses Occurring On or After December 31, 1986 (IITA 207)
100.2320 Determination of the Amount of Illinois Net Loss for Losses Occurring On or After December 31, 1986
100.2330 Illinois Net Loss Carrybacks and Net Loss Carryovers for Losses Occurring On or After December 31, 1986

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.2340 Illinois Net Losses and Illinois Net Loss Deductions for Losses Occurring On or After December 31, 1986, of Corporations that are Members of a Unitary Business Group: Separate Unitary Versus Combined Unitary Returns
100.2350 Illinois Net Losses and Illinois Net Loss Deductions, for Losses Occurring On or After December 31, 1986, of Corporations that are Members of a Unitary Business Group: Changes in Membership

SUBPART E: ADDITIONS TO AND SUBTRACTIONS FROM TAXABLE INCOME OF INDIVIDUALS, CORPORATIONS, TRUSTS AND ESTATES AND PARTNERSHIPS

Section
100.2405 Gross Income, Adjusted Gross Income, Taxable Income and Base Income Defined; Double Deductions Prohibited; Legislative Intention (IITA Section 203(e), (g) and (h))
100.2410 Net Operating Loss Carryovers for Individuals, and Capital Loss and Other Carryovers for All Taxpayers (IITA Section 203)
100.2430 Addition and Subtraction Modifications for Transactions with 80-20 and Noncombination Rule Companies
100.2435 Addition Modification for Student-Assistance Contribution Credit (IITA Sections 203(a)(2)(D-23), (b)(2)(E-16), (c)(2)(G-15), (d)(2)(D-10))
100.2450 IIT Refunds (IITA Section 203(a)(2)(H), (b)(2)(F), (c)(2)(J) and (d)(2)(F))
100.2455 Subtraction Modification: Federally Disallowed Deductions (IITA Sections 203(a)(2)(M), 203(b)(2)(I), 203(c)(2)(L) and 203(d)(2)(J))
100.2470 Subtraction of Amounts Exempt from Taxation by Virtue of Illinois Law, the Illinois or U.S. Constitutions, or by Reason of U.S. Treaties or Statutes (IITA Sections 203(a)(2)(N), 203(b)(2)(J), 203(c)(2)(K) and 203(d)(2)(G))
100.2480 Enterprise Zone Dividend Subtraction (IITA Sections 203(a)(2)(J), 203(b)(2)(K), 203(c)(2)(M) and 203(d)(2)(K))
100.2490 Foreign Trade Zone/High Impact Business Dividend Subtraction (IITA Sections 203(a)(2)(K), 203(b)(2)(L), 203(c)(2)(O), 203(d)(2)(M))

SUBPART F: BASE INCOME OF INDIVIDUALS

Section
100.2510 Subtraction for Contributions to Illinois Qualified Tuition Programs (Section 529 Plans) (IITA Section 203(a)(2)(Y)
100.2580 Medical Care Savings Accounts (IITA Sections 203(a)(2)(D-5), 203(a)(2)(S) and 203(a)(2)(T))

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.2590 Taxation of Certain Employees of Railroads, Motor Carriers, Air Carriers and Water Carriers

SUBPART G: BASE INCOME OF TRUSTS AND ESTATES

Section
100.2655 Subtraction Modification for Enterprise Zone and River Edge Redevelopment Zone Interest (IITA Section 203(b)(2)(M))
100.2680 Capital Gain Income of Estates and Trusts Paid to or Permanently Set Aside for Charity (Repealed)

SUBPART I: GENERAL RULES OF ALLOCATION AND APPORTIONMENT OF BASE INCOME

Section
100.3000 Terms Used in Article 3 (IITA Section 301)
100.3010 Business and Nonbusiness Income (IITA Section 301)
100.3015 Business Income Election (IITA Section 1501)
100.3020 Resident (IITA Section 301)

SUBPART J: COMPENSATION

Section
100.3100 Compensation (IITA Section 302)
100.3110 State (IITA Section 302)
100.3120 Allocation of Compensation Paid to Nonresidents (IITA Section 302)

SUBPART K: NON-BUSINESS INCOME OF PERSONS OTHER THAN RESIDENTS

Section
100.3200 Taxability in Other State (IITA Section 303)
100.3210 Commercial Domicile (IITA Section 303)
100.3220 Allocation of Certain Items of Nonbusiness Income by Persons Other Than Residents (IITA Section 303)

SUBPART L: BUSINESS INCOME OF PERSONS OTHER THAN RESIDENTS

Section

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.3300 Allocation and Apportionment of Base Income (IITA Section 304)
100.3310 Business Income of Persons Other Than Residents (IITA Section 304) − In General
100.3320 Business Income of Persons Other Than Residents (IITA Section 304) − Apportionment (Repealed)
100.3330 Business Income of Persons Other Than Residents (IITA Section 304) − Allocation
100.3340 Business Income of Persons Other Than Residents (IITA Section 304)
100.3350 Property Factor (IITA Section 304)
100.3360 Payroll Factor (IITA Section 304)
100.3370 Sales Factor (IITA Section 304)
100.3371 Sales Factor for Telecommunications Services
100.3373 Sales Factor for Publishing
100.3380 Special Rules (IITA Section 304)
100.3390 Petitions for Alternative Allocation or Apportionment (IITA Section 304(f))
100.3400 Apportionment of Business Income of Financial Organizations for Taxable Years Ending Prior to December 31, 2008 (IITA Section 304(c))
100.3405 Apportionment of Business Income of Financial Organizations for Taxable Years Ending on or after December 31, 2008 (IITA Section 304(c))
100.3420 Apportionment of Business Income of Insurance Companies (IITA Section 304(b))
100.3500 Allocation and Apportionment of Base Income by Nonresident Partners

SUBPART M: ACCOUNTING

Section
100.4500 Carryovers of Tax Attributes (IITA Section 405)

SUBPART N: TIME AND PLACE FOR FILING RETURNS

Section
100.5000 Time for Filing Returns: Individuals (IITA Section 505)
100.5010 Place for Filing Returns: All Taxpayers (IITA Section 505)
100.5020 Extensions of Time for Filing Returns: All Taxpayers (IITA Section 505)
100.5030 Taxpayer's Notification to the Department of Certain Federal Changes Arising in Federal Consolidated Return Years, and Arising in Certain Loss Carryback Years (IITA Section 506)
100.5040 Innocent Spouses

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.5050 Frivolous Returns
100.5060 Reportable Transactions
100.5070 List of Investors in Potentially Abusive Tax Shelters and Reportable Transactions
100.5080 Registration of Tax Shelters (IITA Section 1405.5)

SUBPART O: COMPOSITE RETURNS

Section
100.5100 Composite Returns: Eligibility
100.5110 Composite Returns: Responsibilities of Authorized Agent
100.5120 Composite Returns: Individual Liability
100.5130 Composite Returns: Required forms and computation of Income
100.5140 Composite Returns: Estimated Payments
100.5150 Composite Returns: Tax, Penalties and Interest
100.5160 Composite Returns: Credits on Separate Returns
100.5170 Composite Returns: Definition of a "Lloyd's Plan of Operation"
100.5180 Composite Returns: Overpayments and Underpayments

SUBPART P: COMBINED RETURNS

Section
100.5200 Filing of Combined Returns
100.5201 Definitions and Miscellaneous Provisions Relating to Combined Returns
100.5205 Election to File a Combined Return
100.5210 Procedures for Elective and Mandatory Filing of Combined Returns
100.5215 Filing of Separate Unitary Returns
100.5220 Designated Agent for the Members
100.5230 Combined Estimated Tax Payments
100.5240 Claims for Credit of Overpayments
100.5250 Liability for Combined Tax, Penalty and Interest
100.5260 Combined Amended Returns
100.5265 Common Taxable Year
100.5270 Computation of Combined Net Income and Tax
100.5280 Combined Return Issues Related to Audits

SUBPART Q: REQUIREMENT AND AMOUNT OF WITHHOLDING

Section

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.7000 Requirement of Withholding (IITA Section 701)
100.7010 Compensation Paid in this State (IITA Section 701)
100.7020 Transacting Business Within this State (IITA Section 701)
100.7030 Payments to Residents (IITA Section 701)
100.7035 Nonresident Partners, Subchapter S Corporation Shareholders, and Trust Beneficiaries (IITA Section 709.5)
100.7040 Employer Registration (IITA Section 701)
100.7050 Computation of Amount Withheld (IITA Section 702)
100.7060 Additional Withholding (IITA Section 701)
100.7070 Voluntary Withholding (IITA Section 701)
100.7080 Correction of Underwithholding or Overwithholding (IITA Section 701)
100.7090 Reciprocal Agreement (IITA Section 701)
100.7095 Cross References

SUBPART R: AMOUNT EXEMPT FROM WITHHOLDING

Section
100.7100 Withholding Exemption (IITA Section 702)
100.7110 Withholding Exemption Certificate (IITA Section 702)
100.7120 Exempt Withholding Under Reciprocal Agreements (IITA Section 702)

SUBPART S: INFORMATION STATEMENT

Section
100.7200 Reports for Employee (IITA Section 703)

SUBPART T: EMPLOYER'S RETURN AND PAYMENT OF TAX WITHHELD

Section
100.7300 Returns and Payments of Income Tax Withheld from Wages (IITA Sections 704 and 704A)
100.7310 Returns Filed and Payments Made on Annual Basis (IITA Section 704)
100.7320 Time for Filing Returns and Making Payments for Taxes Required to Be Withheld Prior to January 1, 2008 (IITA Section 704)
100.7325 Time for Filing Returns and Making Payments for Taxes Required to Be Withheld On or After January 1, 2008 (IITA Section 704A)
100.7330 Payment of Tax Required to be Shown Due on a Return (IITA Sections 704 and 704A)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

100.7340 Correction of Underwithholding or Overwithholding (IITA Section 704)
100.7350 Domestic Service Employment (IITA Sections 704 and 704A)
100.7360 Definitions and Special Provisions Relating to Reporting and Payment of Income Tax Withheld (IITA Sections 704 and 704A)
100.7370 Penalty and Interest Provisions Relating to Reporting and Payment of Income Tax Withheld (IITA Sections 704 and 704A)

SUBPART U: ESTIMATED TAX PAYMENTS

Section
100.8000 Payment of Estimated Tax (IITA Section 803)
100.8010 Failure to Pay Estimated Tax (IITA Sections 804 and 806)

SUBPART V: COLLECTION AUTHORITY

Section
100.9000 General Income Tax Procedures (IITA Section 901)
100.9010 Collection Authority (IITA Section 901)
100.9020 Child Support Collection (IITA Section 901)

SUBPART W: NOTICE AND DEMAND

Section
100.9100 Notice and Demand (IITA Section 902)

SUBPART X: ASSESSMENT

Section
100.9200 Assessment (IITA Section 903)
100.9210 Waiver of Restrictions on Assessment (IITA Section 907)

SUBPART Y: DEFICIENCIES AND OVERPAYMENTS

Section
100.9300 Deficiencies and Overpayments (IITA Section 904)
100.9310 Application of Tax Payments Within Unitary Business Groups (IITA Section 603)
100.9320 Limitations on Notices of Deficiency (IITA Section 905)
100.9330 Further Notices of Deficiency Restricted (IITA Section 906)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

SUBPART Z: CREDITS AND REFUNDS

Section
100.9400 Credits and Refunds (IITA Section 909)
100.9410 Limitations on Claims for Refund (IITA Section 911)
100.9420 Recovery of Erroneous Refund (IITA Section 912)

SUBPART AA: INVESTIGATIONS AND HEARINGS

Section
100.9500 Access to Books and Records (IITA Section 913)
100.9505 Access to Books and Records − 60-Day Letters (IITA Section 913) (Repealed)
100.9510 Taxpayer Representation and Practice Requirements
100.9520 Conduct of Investigations and Hearings (IITA Section 914)
100.9530 Books and Records

SUBPART BB: JUDICIAL REVIEW

Section
100.9600 Administrative Review Law (IITA Section 1201)

SUBPART CC: DEFINITIONS

Section
100.9700 Unitary Business Group Defined (IITA Section 1501)
100.9710 Financial Organizations (IITA Section 1501)
100.9720 Nexus
100.9730 Investment Partnerships (IITA Section 1501(a)(11.5))
100.9750 Corporation, Subchapter S Corporation, Partnership and Trust Defined (IITA Section 1501)

SUBPART DD: LETTER RULING PROCEDURES

Section
100.9800 Letter Ruling Procedures

SUBPART EE: MISCELLANEOUS

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

Section
100.9900 Tax Shelter Voluntary Compliance Program

100.APPENDIX A Business Income Of Persons Other Than Residents
100.TABLE A Example of Unitary Business Apportionment
100.TABLE B Example of Unitary Business Apportionment for Groups Which Include Members Using Three-Factor and Single-Factor Formulas

AUTHORITY: Implementing the Illinois Income Tax Act [35 ILCS 5] and authorized by Section 1401 of the Illinois Income Tax Act [35 ILCS 5/1401].

SOURCE: Filed July 14, 1971, effective July 24, 1971; amended at 2 Ill. Reg. 49, p. 84, effective November 29, 1978; amended at 5 Ill. Reg. 813, effective January 7, 1981; amended at 5 Ill. Reg. 4617, effective April 14, 1981; amended at 5 Ill. Reg. 4624, effective April 14, 1981; amended at 5 Ill. Reg. 5537, effective May 7, 1981; amended at 5 Ill. Reg. 5705, effective May 20, 1981; amended at 5 Ill. Reg. 5883, effective May 20, 1981; amended at 5 Ill. Reg. 6843, effective June 16, 1981; amended at 5 Ill. Reg. 13244, effective November 13, 1981; amended at 5 Ill. Reg. 13724, effective November 30, 1981; amended at 6 Ill. Reg. 579, effective December 29, 1981; amended at 6 Ill. Reg. 9701, effective July 26, 1982; amended at 7 Ill. Reg. 399, effective December 28, 1982; amended at 8 Ill. Reg. 6184, effective April 24, 1984; codified at 8 Ill. Reg. 19574; amended at 9 Ill. Reg. 16986, effective October 21, 1985; amended at 9 Ill. Reg. 685, effective December 31, 1985; amended at 10 Ill. Reg. 7913, effective April 28, 1986; amended at 10 Ill. Reg. 19512, effective November 3, 1986; amended at 10 Ill. Reg. 21941, effective December 15, 1986; amended at 11 Ill. Reg. 831, effective December 24, 1986; amended at 11 Ill. Reg. 2450, effective January 20, 1987; amended at 11 Ill. Reg. 12410, effective July 8, 1987; amended at 11 Ill. Reg. 17782, effective October 16, 1987; amended at 12 Ill. Reg. 4865, effective February 25, 1988; amended at 12 Ill. Reg. 6748, effective March 25, 1988; amended at 12 Ill. Reg. 11766, effective July 1, 1988; amended at 12 Ill. Reg. 14307, effective August 29, 1988; amended at 13 Ill. Reg. 8917, effective May 30, 1989; amended at 13 Ill. Reg. 10952, effective June 26, 1989; amended at 14 Ill. Reg. 4558, effective March 8, 1990; amended at 14 Ill. Reg. 6810, effective April 19, 1990; amended at 14 Ill. Reg. 10082, effective June 7, 1990; amended at 14 Ill. Reg. 16012, effective September 17, 1990; emergency amendment at 17 Ill. Reg. 473, effective December 22, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 8869, effective June 2, 1993; amended at 17 Ill. Reg. 13776, effective August 9, 1993; recodified at 17 Ill. Reg. 14189; amended at 17 Ill. Reg. 19632, effective November 1, 1993; amended at 17 Ill. Reg. 19966, effective November 9, 1993; amended at 18 Ill. Reg. 1510, effective January 13, 1994; amended at 18 Ill. Reg. 2494, effective January 28, 1994; amended at 18 Ill. Reg. 7768, effective May 4, 1994; amended at 19 Ill. Reg. 1839,

effective February 6, 1995; amended at 19 Ill. Reg. 5824, effective March 31, 1995; emergency amendment at 20 Ill. Reg. 1616, effective January 9, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 6981, effective May 7, 1996; amended at 20 Ill. Reg. 10706, effective July 29, 1996; amended at 20 Ill. Reg. 13365, effective September 27, 1996; amended at 20 Ill. Reg. 14617, effective October 29, 1996; amended at 21 Ill. Reg. 958, effective January 6, 1997; emergency amendment at 21 Ill. Reg. 2969, effective February 24, 1997, for a maximum of 150 days; emergency expired July 24, 1997; amended at 22 Ill. Reg. 2234, effective January 9, 1998; amended at 22 Ill. Reg. 19033, effective October 1, 1998; amended at 22 Ill. Reg. 21623, effective December 15, 1998; amended at 23 Ill. Reg. 3808, effective March 11, 1999; amended at 24 Ill. Reg. 10593, effective July 7, 2000; amended at 24 Ill. Reg. 12068, effective July 26, 2000; emergency amendment at 24 Ill. Reg. 17585, effective November 17, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 18731, effective December 11, 2000; amended at 25 Ill. Reg. 4640, effective March 15, 2001; amended at 25 Ill. Reg. 4929, effective March 23, 2001; amended at 25 Ill. Reg. 5374, effective April 2, 2001; amended at 25 Ill. Reg. 6687, effective May 9, 2001; amended at 25 Ill. Reg. 7250, effective May 25, 2001; amended at 25 Ill. Reg. 8333, effective June 22, 2001; amended at 26 Ill. Reg. 192, effective December 20, 2001; amended at 26 Ill. Reg. 1274, effective January 15, 2002; amended at 26 Ill. Reg. 9854, effective June 20, 2002; amended at 26 Ill. Reg. 13237, effective August 23, 2002; amended at 26 Ill. Reg. 15304, effective October 9, 2002; amended at 26 Ill. Reg. 17250, effective November 18, 2002; amended at 27 Ill. Reg. 13536, effective July 28, 2003; amended at 27 Ill. Reg. 18225, effective November 17, 2003; emergency amendment at 27 Ill. Reg. 18464, effective November 20, 2003, for a maximum of 150 days; emergency expired April 17, 2004; amended at 28 Ill. Reg. 1378, effective January 12, 2004; amended at 28 Ill. Reg. 5694, effective March 17, 2004; amended at 28 Ill. Reg. 7125, effective April 29, 2004; amended at 28 Ill. Reg. 8881, effective June 11, 2004; emergency amendment at 28 Ill. Reg. 14271, effective October 18, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 14868, effective October 26, 2004; emergency amendment at 28 Ill. Reg. 15858, effective November 29, 2004, for a maximum of 150 days; amended at 29 Ill. Reg. 2420, effective January 28, 2005; amended at 29 Ill. Reg. 6986, effective April 26, 2005; amended at 29 Ill. Reg. 13211, effective August 15, 2005; amended at 29 Ill. Reg. 20516, effective December 2, 2005; amended at 30 Ill. Reg. 6389, effective March 30, 2006; amended at 30 Ill. Reg. 10473, effective May 23, 2006; amended by 30 Ill. Reg. 13890, effective August 1, 2006; amended at 30 Ill. Reg. 18739, effective November 20, 2006; amended at 31 Ill. Reg. 16240, effective November 26, 2007; amended at 32 Ill. Reg. 872, effective January 7, 2008; amended at 32 Ill. Reg. 1407, effective January 17, 2008; amended at 32 Ill. Reg. 3400, effective February 25, 2008; amended at 32 Ill. Reg. 6055, effective March 25, 2008; amended at 32 Ill. Reg. 10170, effective June 30, 2008; amended at 32 Ill. Reg. 13223, effective July 24, 2008; amended at 32 Ill. Reg. 17492, effective October 24, 2008; amended at 33 Ill. Reg. 1195, effective December 31, 2008; amended at 33 Ill. Reg. 2306, effective January 23, 2009; amended

at 33 Ill. Reg. 14168, effective September 28, 2009; amended at 33 Ill. Reg. 15044, effective October 26, 2009; amended at 34 Ill. Reg. 550, effective December 22, 2009; amended at 34 Ill. Reg. 3886, effective March 12, 2010; amended at 34 Ill. Reg. 12891, effective August 19, 2010; amended at 35 Ill. Reg. 4223, effective February 25, 2011; amended at 35 Ill. Reg. 15092, effective August 24, 2011; amended at 36 Ill. Reg. 2363, effective January 25, 2012; amended at 36 Ill. Reg. 9247, effective June 5, 2012; amended at 37 Ill. Reg. 5823, effective April 19, 2013; amended at 37 Ill. Reg. 20751, effective December 13, 2013; amended at 38 Ill. Reg. _____, effective _____.

SUBPART B: CREDITS

Section 100.2171 Angel Investment Credit (IITA 220)

a) For taxable years beginning on and after January 1, 2011, and ending before January 1, 2017, a claimant (as defined under 14 Ill. Adm. Code 531.20) may claim a credit against the tax imposed under IITA Sections 201(a) and (b) in an amount equal to 25% of the Angel Investment (as defined under 14 Ill. Adm. Code 531.20) made by the claimant and that is shown on the Tax Credit Certificate issued by the Department of Commerce and Economic Opportunity (DCEO) under 14 Ill. Adm. Code 531.70. *A claimant may not sell or otherwise transfer a credit awarded under this Section to another person.* (IITA Section 220(g))

b) Year in Which Credit is Taken. The credit allowed under this Section shall be taken in the taxable year that includes the date of the Tax Credit Certificate issued by DCEO under 14 Ill. Adm. Code 531.70.

c) In the case of a credit earned by a partnership or subchapter S corporation, the credit passes through to the owners as provided in the partnership agreement under IRC section 704(a) or in proportion to their ownership of the stock of the subchapter S corporation under IRC section 1366(a). The credit earned by a partnership or subchapter S corporation will be treated as earned by its owners as of the last day of the taxable year of the partnership or subchapter S corporation in which the Tax Credit Certificate is issued by DCEO under 14 Ill. Adm. Code 531.70, and shall be allowed to each owner in the taxable year of the owner in which the taxable year of the partnership or subchapter S corporation ends.

d) *The credit under this Section may not exceed the taxpayer's Illinois income tax liability under IITA Section 201(a) and (b) for the taxable year. If the amount of the credit exceeds the tax liability for the year, the excess may be carried forward and applied to the tax liability of the 5 taxable years following the excess credit year. The credit shall be applied to the earliest year for which there is a tax liability. If there are credits from more than one tax year that are available to offset a liability, the earlier credit shall be applied first.* (IITA Section 220(b))

e) Recapture. *If,* as determined by DCEO, *an investment for which a claimant is allowed a credit under this Section is held by the claimant for less than 3 years, or, if within that period of time the qualified new business venture is moved from the State, the claimant shall pay to the Department of Revenue*, on forms prescribed by the Department of Revenue, *the amount of the credit that the claimant received related to the investment. DCEO shall annually certify that the claimant's investment has been made and remains in the qualified new business venture for no less than 3 years.* (IITA Section 220(d))

f) Documentation of the Credit. A claimant shall attach to its Illinois income tax return a copy of the Tax Credit Certificate and/or annual certification (if any) issued by DCEO and, in the case of a partner in a partnership or shareholder of a subchapter S corporation that earned the credit, a Schedule K-1-P or other written statement from the partnership or subchapter S corporation stating the portion of the total credit shown on the Tax Credit Certificate that is allowed to that partner or shareholder and the taxable year of the partnership or subchapter S corporation in which the Tax Credit Certificate was issued.

(Source: Added at 38 Ill. Reg._____, effective_____)

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Issuance of Licenses

2) Code Citation: 92 Ill. Adm. Code 1030

3)

Section Numbers:	Proposed Action:
1030.1	Amend
1030.5	Amend
1030.6	Amend
1030.7	Amend
1030.65	Amend
1030.66	New

4) Statutory Authority: 625 ILCS 5/6-107.5

5) A Complete Description of the Subjects and Issues Involved: This rulemaking will implement PA 98-167, effective July 1, 2014 that requires driver's license applicant's between the ages of 18 and 20 who have never previously been licensed or completed an approved driver education course to complete six hours of adult driver education.

The rulemaking sets forth requirements for existing licensed commercial driver training schools to offer the adult education program, in either a classroom or online setting. The rule also set forth requirements for those entities that are not currently licensed as commercial driver training schools to obtain certification to offer online-only adult driver education. Requirements for online providers include submission of an application, a fingerprint-based background check, surety bond, approval by the Secretary of the proposed course content and verification of student participation and identity.

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? Yes

Section Numbers:	Proposed Action:	*Illinois Register* Citation:

1030.1	Amendment	37 Ill. Reg. 20117; December 20, 2013
1030.85	Amendment	37 Ill. Reg. 20117; December 20, 2013
1030.Appendix A	Amendment	37 Ill. Reg. 20117; December 20, 2013
1030.Appendix B	Amendment	37 Ill. Reg. 20117; December 20, 2013

11) Statement of Statewide Policy Objective: The rulemaking will not create or enlarge a State mandate.

12) Time, place and anner in which interested persons may comment on this proposed rulemaking: Text of the prepared amendments is posted on the Secretary of State's website, www.sos.il.us/departments/index/home as part of the *Illinois Register*. Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after publication of this Notice to:

Jennifer Egizii
Office of the Secretary of State
Driver Services Department
2701 South Dirksen Parkway
Springfield IL 62723

217-557-4462

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Existing commercial driver training schools and new entities wishing to offer adult driver education, either in a classroom or online setting

B) Reporting, bookkeeping or other procedures required for compliance: Applicants will be required to complete an application to offer adult driver education and undergo a fingerprint-based background check and maintain a continuous surety bond. Once certified, providers will be required to maintain records of student enrollment, attendance and completion and will be required to report enrollment and completion to the Secretary of State.

C) Types of Professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2014

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

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

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1030
ISSUANCE OF LICENSES

Section
1030.1 Definitions
1030.5 Procedure for Obtaining a Driver's License
1030.6 Procedure for Obtaining a Visa Status Temporary Visitor's Driver's License Pursuant to IVC Section 6-105.1(a)
1030.7 Procedure for Obtaining a Non-Visa Status Temporary Visitor's Driver's License Pursuant to IVC Section 6-105.1(a-5)
1030.10 What Persons Shall Not be Licensed or Granted Permits
1030.11 Procedure for Obtaining a Driver's License/Temporary Visitor's Driver's License (Renumbered)
1030.12 Identification Cards for the Homeless
1030.13 Denial of License or Permit
1030.14 Emergency Contact Database
1030.15 Cite for Re-testing
1030.16 Physical and Mental Evaluation
1030.17 Errors in Issuance of Driver's License/Cancellation
1030.18 Medical Criteria Affecting Driver Performance
1030.20 Classification of Drivers – References (Repealed)
1030.22 Medical Examiner's Certificate − CDL Holders
1030.25 Safe Driver License Renewals
1030.30 Classification Standards
1030.40 Fifth Wheel Equipped Trucks
1030.50 Bus Driver's Authority, Religious Organization and Senior Citizen Transportation
1030.55 Commuter Van Driver Operating a For-Profit Ridesharing Arrangement
1030.60 Third-Party Certification Program
1030.63 Religious Exemption for Social Security Numbers (Repealed)
1030.65 Instruction Permits
1030.66 Adult Driver Education
1030.70 Driver's License Testing/Vision Screening
1030.75 Driver's License Testing/Vision Screening With Vision Aid Arrangements Other Than Standard Eye Glasses or Contact Lenses
1030.80 Driver's License Testing/Written Test
1030.81 Endorsements

1030.82 Charter Bus Driver Endorsement Requirements
1030.83 Hazardous Material Endorsement
1030.84 Vehicle Inspection
1030.85 Driver's License Testing/Road Test
1030.86 Multiple Attempts − Written and/or Road Tests
1030.88 Exemption of Facility Administered Road Test
1030.89 Temporary Driver's Licenses and Temporary Instruction Permits
1030.90 Requirement for Photograph and Signature of Licensee on Driver's License
1030.91 Person with a Disability Identification Card
1030.92 Restrictions
1030.93 Restricted Local Licenses
1030.94 Duplicate or Corrected Driver's License or Instruction Permit
1030.95 Consular Licenses (Repealed)
1030.96 Seasonal Restricted Commercial Driver's License
1030.97 Invalidation of a Driver's License, Permit and/or Driving Privilege
1030.98 School Bus Endorsement or Instruction Permit
1030.100 Anatomical Gift Donor (Repealed)
1030.110 Emergency Medical Information Card
1030.115 Change-of-Address
1030.120 Issuance of a Probationary License
1030.130 Grounds for Cancellation of a Probationary License
1030.140 Use of Captured Images
1030.APPENDIX A Questions Asked of a Driver's License Applicant
1030.APPENDIX B Acceptable Identification Documents – Applicants for a Driver's License, Instruction Permit, Visa Status Temporary Visitor's Driver's License Pursuant to IVC Section 6-105.1(a) or Visa Status Temporary Visitor's Instruction Permit
1030.APPENDIX C Acceptable Identification Documents – Applicants for a Non-Visa Status Temporary Visitor's Driver's License or Non-Visa Status Temporary Visitor's Instruction Permit Pursuant to IVC Section 6-105.1(a-5)

AUTHORITY: Implementing Article I of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 6, Art. I] and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed March 30, 1971; amended at 3 Ill. Reg. 7, p. 13, effective April 2, 1979; amended at 4 Ill. Reg. 27, p. 422, effective June 23, 1980; amended at 6 Ill. Reg. 2400, effective February 10, 1982; codified at 6 Ill. Reg. 12674; amended at 9 Ill. Reg. 2716, effective February

20, 1985; amended at 10 Ill. Reg. 303, effective December 24, 1985; amended at 10 Ill. Reg. 15130, effective September 2, 1986; amended at 10 Ill. Reg. 18182, effective October 14, 1986; amended at 11 Ill. Reg. 9331, effective April 28, 1987; amended at 11 Ill. Reg. 18292, effective October 23, 1987; amended at 12 Ill. Reg. 3027, effective January 14, 1988; amended at 12 Ill. Reg. 13221, effective August 1, 1988; amended at 12 Ill. Reg. 16915, effective October 1, 1988; amended at 12 Ill. Reg. 19777, effective November 15, 1988; amended at 13 Ill. Reg. 5192, effective April 1, 1989; amended at 13 Ill. Reg. 7808, effective June 1, 1989; amended at 13 Ill. Reg. 12880, effective July 19, 1989; amended at 13 Ill. Reg. 12978, effective July 19, 1989; amended at 13 Ill. Reg. 13898, effective August 22, 1989; amended at 13 Ill. Reg. 15112, effective September 8, 1989; amended at 13 Ill. Reg. 17095, effective October 18, 1989; amended at 14 Ill. Reg. 4570, effective March 8, 1990; amended at 14 Ill. Reg. 4908, effective March 9, 1990; amended at 14 Ill. Reg. 5183, effective March 21, 1990; amended at 14 Ill. Reg. 8707, effective May 16, 1990; amended at 14 Ill. Reg. 9246, effective May 16, 1990; amended at 14 Ill. Reg. 9498, effective May 17, 1990; amended at 14 Ill. Reg. 10111, effective June 11, 1990; amended at 14 Ill. Reg. 10510, effective June 18, 1990; amended at 14 Ill. Reg. 12077, effective July 5, 1990; amended at 14 Ill. Reg. 15487, effective September 10, 1990; amended at 15 Ill. Reg. 15783, effective October 18, 1991; amended at 16 Ill. Reg. 2182, effective January 24, 1992; emergency amendment at 16 Ill. Reg. 12228, effective July 16, 1992, for a maximum of 150 days; emergency expired on December 13, 1992; amended at 16 Ill. Reg. 18087, effective November 17, 1992; emergency amendment at 17 Ill. Reg. 1219, effective January 13, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 2025, effective February 1, 1993; amended at 17 Ill. Reg. 7065, effective May 3, 1993; amended at 17 Ill. Reg. 8275, effective May 24, 1993; amended at 17 Ill. Reg. 8522, effective May 27, 1993; amended at 17 Ill. Reg. 19315, effective October 22, 1993; amended at 18 Ill. Reg. 1591, effective January 14, 1994; amended at 18 Ill. Reg. 7478, effective May 2, 1994; amended at 18 Ill. Reg. 16457, effective October 24, 1994; amended at 19 Ill. Reg. 10159, effective June 29, 1995; amended at 20 Ill. Reg. 3891, effective February 14, 1996; emergency amendment at 20 Ill. Reg. 8358, effective June 4, 1996, for a maximum of 150 days; emergency amendment repealed in response to an objection of the Joint Committee on Administrative Rules at 20 Ill. Reg. 14279; amended at 21 Ill. Reg. 6588, effective May 19, 1997; amended at 21 Ill. Reg. 10992, effective July 29, 1997; amended at 22 Ill. Reg. 1466, effective January 1, 1998; emergency amendment at 23 Ill. Reg. 9552, effective August 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13947, effective November 8, 1999; amended at 24 Ill. Reg. 1259, effective January 7, 2000; emergency amendment at 24 Ill. Reg. 1686, effective January 13, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 6955, effective April 24, 2000; emergency amendment at 24 Ill. Reg. 13044, effective August 10, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 18400, effective December 4, 2000; amended at 25 Ill. Reg. 959, effective January 5, 2001; amended at 25 Ill. Reg. 7742, effective June 5, 2001; amended at 25 Ill. Reg. 12646, effective September 24, 2001; emergency amendment at 25 Ill. Reg. 12658, effective September 24, 2001, for a maximum of 150 days;

emergency expired February 20, 2002; amended at 26 Ill. Reg. 9961, effective June 24, 2002; amended at 27 Ill. Reg. 855, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 7340, effective April 14, 2003, for a maximum of 150 days; emergency expired September 10, 2003; emergency amendment at 27 Ill. Reg. 16968, effective October 17, 2003, for a maximum of 150 days; emergency expired March 14, 2004; emergency amendment at 28 Ill. Reg. 384, effective January 1, 2004, for a maximum of 150 days; emergency expired May 29, 2004; amended at 28 Ill. Reg. 8895, effective June 14, 2004; amended at 28 Ill. Reg. 10776, effective July 13, 2004; amended at 29 Ill. Reg. 920, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2469, effective January 31, 2005, for a maximum of 150 days; emergency expired June 29, 2005; amended at 29 Ill. Reg. 9488, effective June 17, 2005; amended at 29 Ill. Reg. 12519, effective July 28, 2005; amended at 29 Ill. Reg. 13237, effective August 11, 2005; amended at 29 Ill. Reg. 13580, effective August 16, 2005; amended at 30 Ill. Reg. 910, effective January 6, 2006; amended at 30 Ill. Reg. 5621, effective March 7, 2006; amended at 30 Ill. Reg. 11365, effective June 15, 2006; emergency amendment at 30 Ill. Reg. 11409, effective June 19, 2006, for a maximum of 150 days; emergency expired November 15, 2006; amended at 31 Ill. Reg. 4782, effective March 12, 2007; amended at 31 Ill. Reg. 5096, effective March 15, 2007; amended at 31 Ill. Reg. 5864, effective March 29, 2007; amended at 31 Ill. Reg. 6370, effective April 12, 2007; amended at 31 Ill. Reg. 7643, effective May 16, 2007; amended at 31 Ill. Reg. 11342, effective July 18, 2007; amended at 31 Ill. Reg. 14547, effective October 9, 2007; amended at 31 Ill. Reg. 14849, effective October 22, 2007; amended at 31 Ill. Reg. 16543, effective November 27, 2007; amended at 31 Ill. Reg. 16843, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 208, effective January 2, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 6544, effective April 4, 2008; amended at 33 Ill. Reg. 2391, effective January 21, 2009; amended at 33 Ill. Reg. 8489, effective June 5, 2009; amended at 33 Ill. Reg. 9794, effective June 29, 2009; amended at 33 Ill. Reg. 11620, effective July 22, 2009; amended at 33 Ill. Reg. 14185, effective September 28, 2009; amended at 34 Ill. Reg. 563, effective December 22, 2009; amended at 34 Ill. Reg. 9457, effective June 23, 2010; amended at 34 Ill. Reg. 15418, effective September 22, 2010; amended at 34 Ill. Reg. 19071, effective November 22, 2010; amended at 35 Ill. Reg. 2197, effective January 21, 2011; amended at 35 Ill. Reg. 4692, effective March 3, 2011; amended at 35 Ill. Reg. 19664, effective November 23, 2011; amended at 36 Ill. Reg. 3924, effective February 27, 2012; amended at 36 Ill. Reg. 7255, effective April 26, 2012; amended at 36 Ill. Reg. 14755, effective September 18, 2012; amended at 37 Ill. Reg. 7776, effective May 22, 2013; amended at 37 Ill. Reg. 14176, effective September 1, 2013; amended at 37 Ill. Reg. 19342, effective November 28, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 1030.1 Definitions

Unless otherwise noted, the following definitions shall apply to this Part.

"Acceptable Medical Certificate" − a current medical examiner's certificate that has been completed in its entirety and does not require additional information.

"Adjudication of Disability" − an order by a court of competent jurisdiction declaring a person, unable to fully manage his/her person and/or estate because of mental deterioration or physical incapacity, or mental illness or developmental disability, pursuant to Sections 11a-1, 11a-2 and 11a-3 of the Probate Act of 1975 [755 ILCS 5/11a-1, 11a-2 and 11a-3].

"Adult Driver Education Course" − six hour classroom or online course of driver education for persons age 18, 19 or 20, offered by an adult driver education course provider.

"Adult Driver Education Course Provider" or "Provider" − an entity certified by the Secretary of State to provide an adult driver education course, either in a classroom setting or online.

"Agri-Chemical Business" – any individual, partnership, corporation or association engaged in a business operation for the purpose of selling or distributing agricultural pesticides and/or fertilizers or providing the service of application of these substances in this State.

"Applicant" – a person applying for an Illinois driver's license, permit or identification card.

"Approved Driver Education Course" –

> *a course of driver education approved by the State Board of Education, offered by public or private schools maintaining grades 9 through 12, and meeting at least the minimum requirements of the Driver Education Act* [105 ILCS 5/27-24 through 27-24.8]; *or*
>
> *a course of driver education offered by a school licensed to give driver education instructions under the Vehicle Code that meets at least the minimum educational requirements of the Driver Education Act and is approved by the State Board of Education; or*

any course of driver education given at a Department of Defense Education Activity school that is approved by the Department of Defense Education Activity and taught by an adult driver education instructor or traffic safety officer; or

a course of driver education given in another state to an Illinois resident attending school in that state and approved by the state administrator of the driver education program of the other state [625 ILCS 5/1-103].

"Armed Forces" – the United States Army, Navy, Air Force, Marine Corps or Coast Guard; Illinois National Guard; service in the Merchant Marine that constitutes active duty under Section 401 of the Federal Public Law 95-202 (38 USC 106) shall also be considered service in the Armed Forces of the United States.

"Authorized Secretary of State Employee" − a Secretary of State employee with a supervisory position.

"Authorized Source" −

competent medical specialist

law enforcement official

member of the judiciary

Member of the Board

National Driver Register

authorized Secretary of State employee

employee of the U.S. Department of Transportation, Office of Motor Carriers

motor vehicle departments of foreign states

driver rehabilitation specialist

problem driver pointer system

"Binocular Visual Acuity" – a visual reading obtained utilizing both eyes at the same time.

"Branch Facility" – a separate training/testing facility operated and directly supervised by a third-party certifying entity at a location different from the principal location of the third-party certifying entity.

"Business Day" – any day on which the Office of the Secretary of State is open; generally, Monday through Saturday, excluding State holidays.

"CDL Skills Test" – a test given to an applicant who is attempting to obtain a Commercial Driver's License (CDL).

"CDLIS Driver Record" – the electronic record of the individual CDL driver's status and history stored by the State-of-Record as part of the Commercial Driver's License Information System, or CDLIS, established under 49 USC 31309. [625 ILCS 5/6-500(5.3)]

"CDLIS Motor Vehicle Record" or "CDLIS MVR" − a report generated from the CDLIS driver record meeting the requirements for access to CDLIS information and provided by states to users authorized in 49 CFR 384.225(e)(3) and (4) (2011)*, subject to the provisions of the Driver Privacy Protection Act (18 USC 2721-2725).* [625 ILCS 5/6-500(5.5)]

"Commercial Driver's License Downgrade" − a state:

allows the driver to change his or her self certification to interstate, but operating exclusively in transportation or operation excepted from 49 CFR 391 (2011)*, as provided in 49 CFR 390.3(f), 391.2, 391.68 or 398.3* (2011)*;*

allows the driver to change his or her self-certification to intrastate only, if the driver qualifies under that state's physical qualification requirements for intrastate only;

allows the driver to change his or her self-certification to intrastate, but operating exclusively in transportation or operations excepted from all or part of the state driver qualification requirements; or

removes the CDL privilege from the driver's license. [625 ILCS 5/6-500(5.7)]

"Cancellation" – the annulment or termination by formal action of the Secretary of a person's driver's license or permit because of some error or defect in the license or because the licensee is no longer entitled to such license or permit, but, with the exception of Sections 6-107, 6-108 and 6-201, the cancellation of a license or permit is without prejudice and application for a new license or permit may be made at any time after such cancellation [625 ILCS 5/1-110 and 5/6-206(c)(3) and 6-201].

"Central Issuance" − the process of printing and mailing a driver's license to an applicant from a secure central production facility.

"Certificate of Completion" – a certificate of completion issued by the Office of the Secretary of State if the student has successfully completed his/her driver education course at an approved commercial driver training school as provided in IVC Chapter 6, Art. IV and 92 Ill. Adm. Code 1060.

"Charter Bus Driver Endorsement" – an indicator on the driver's license that the driver is qualified to transport a group of persons with a common purpose, under a single contract at a fixed rate for their exclusive use of that motor vehicle.

"Cheating on Written Tests" – the receipt or use of unauthorized assistance in the taking of any portion of a written test. This includes, but is not limited to, the use of any notes, books or written information.

"Cited Driver" − a driver who has been requested by the Secretary of State to appear for re-test.

"Classification" – a designation as to the kind and type of vehicle a driver is entitled to operate, as outlined in Sections 1030.30 and 1030.40.

"Classroom Instruction" – the part of an approved driver education course consisting of learning experiences in the classroom. This instruction must be of

the type to satisfy the 30 clock hours of instruction specified in Section 27-23 of the School Code [105 ILCS 5/27-23].

"Cleared Miscellaneous Suspension" – a suspension for safety responsibility, financial responsibility, warrant parking/traffic, auto emissions, failure to appear, curfew, mandatory conviction, tollway, family financial responsibility, automated traffic law violation, nighttime driving restriction, or unsatisfied judgment.

"Commercial Driver's License" or "CDL" − *a license issued by a state* or other jurisdiction, in accordance with the standards contained in 49 CFR 383, *to an individual*, *that authorizes the individual to operate a certain class of commercial motor vehicle* [625 ILCS 5/1-111.6].

"Commercial Driver's License Information System" or "CDLIS" – the information system established pursuant to the Commercial Motor Vehicle Safety Act of 1986 (CMVSA) to serve as a clearinghouse for locating information related to the licensing and identification of commercial motor vehicle drivers.

"Commercial Driver Instruction Permit" or "CIP" – a permit issued pursuant to IVC Section 6-508.

"Commercial Motor Vehicle" or "CMV" – *a motor vehicle or combination of motor vehicles used in commerce to transport passengers or property if the motor vehicle –*

> *has a gross combination weight rating of* 11,794 kilograms *(26,000 pounds) or more inclusive of towed units with a gross vehicle weight rating of more than 4,536 kilograms (10,000 pounds); or*
>
> *has a gross vehicle weight rating of* 11,794 kilograms *(26,001 pounds) or more; or*
>
> *is designed to transport 16 or more passengers, including the driver; or*
>
> *is of any size and is used in the transportation of hazardous materials* as defined in the Federal Motor Carrier Safety Regulations (49 CFR 383.5 (October 1, 2012)). [625 ILCS 5/6-500(6)]

"Commuter Van" – a motor vehicle designed for the transportation of not less than seven or more than 16 passengers, that is used in a ridesharing arrangement [625 ILCS 5/1-111.9].

"Competent Medical Specialist" − a person licensed under the Medical Practice Act [225 ILCS 60], or similar law of another jurisdiction, to practice medicine in all of its branches.

"Confirmed Medical Emergency" – documented medical emergency from a licensed physician specifying the cited driver is unable to appear during the 30 day re-testing period. This includes, but is not necessarily limited to, the following conditions: hospitalization, serious illness, broken limbs.

"Consular Identification Document" – an official identification card issued by a foreign government that meets the criteria set forth in Section 5 of the Consular Identification Document Act [5 ILCS 230/5] and the issuing consulate has filed with the Department of State Police a copy of the consular identification document and a certification of the procedures that are used to satisfy Sections 2 and 3 of the Consular Identification Document Act.

"Conviction" − A final adjudication of guilty by a court of competent jurisdiction after a bench trial, trial by jury, plea of guilty, order of forfeiture, or default [625 ILCS 5/6-100(b)].

"Conviction-CDL Holder" – an unvacated adjudication of guilt, or a determination that a person has violated or failed to comply with the law in a court of original jurisdiction or by an authorized administrative tribunal; an unvacated forfeiture of bail or collateral deposited to secure the person's appearance in court; a plea of guilty or nolo contendere accepted by the court; the payment of a fine or court cost regardless of whether the imposition of sentence is deferred and ultimately a judgment dismissing the underlying charge is entered; or a violation of a condition of release without bail, regardless of whether or not the penalty is rebated, suspended or probated [625 ILCS 5/6-500(8)].

"Cooperative Driver Certificate" – a certificate prescribed by the Secretary of State indicating a successfully-completed road test, subject to spot check by the Secretary of State, was administered to a driver education student, who has

successfully completed driver training by an Illinois State Board of Education approved driver education instructor.

"Cooperative Driver Testing Program" – a program offered by the Department to local school boards with accredited driver education courses, allowing students who receive a grade of A or B in the driver education course and who pass a road test administered by a Department certified high school driver education instructor to be exempted from a road test administered by the Department.

"Court Documents" – the items issued by a court, such as reports, notices, summonses, subpoenas, orders and transcripts.

"Criminal Justice Agencies" − the federal and state courts, a governmental agency or sub-unit that performs the duties of the detection, apprehension or detention of accused persons or criminal offenders pursuant to a statute.

"Current Medical Report" − any medical report completed within 90 days after receipt by the Department that is signed and dated by a competent medical specialist.

"Current Telescopic Lens Vision Specialist Report" – any vision specialist report completed for a telescopic lens user that has been completed within six months prior to receipt by the Department and is signed and dated by a licensed vision specialist.

"Current Vision Specialist Report" – any vision specialist report completed for a driver that has been completed within six months prior to receipt by the Department and is signed and dated by a vision specialist.

"Custom Harvester" – any individual, partnership, corporation or association engaged in a business operation for the purpose of harvesting agricultural commodities other than their own on a contract basis.

"Dangerous Action" – an act by the applicant that could endanger a person or property.

"Day" − a calendar day.

"Denial" – any entry on a person's driving record by the Department indicating a driver may not renew his/her driver's license or privileges until the conditions set forth by the Department are met (see IVC Section 6-103).

"Denial of Driver's License" − the act of prohibiting or disallowing the privilege to obtain a driver's license while allowing the privilege to obtain an instructional permit and limiting privileges to that of an instructional permit if a driver's license has previously been issued (see IVC Section 6-107(c) and (d)).

"Denial of Driving Privilege" − the act of prohibiting or disallowing the privilege to obtain a driver's license or permit and/or the privilege to operate a motor vehicle (see IVC Sections 6-103, 6-107(c), 6-108.1).

"Department" − the Department of Driver Services within the Office of the Secretary of State.

"Department of Administrative Hearings" − the Department of Administrative Hearings of the Office of the Secretary of State.

"Determination of No Security Threat" – an administrative determination by TSA that an individual does not pose a security threat warranting denial of a Hazardous Material Endorsement.

"Disabled Person Identification Card" – a standard identification card as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335/4A] issued for no fee to persons who meet the definition of disabled (see IVC Section 1-159.1).

"Disability" − an individual's physical or mental impairment that substantially limits one or more of the major life activities; a record of such impairment, or when the individual is regarded as having such impairment [625 ILCS 5/6-117.2(f)].

"Disqualification" − a disqualification means any of the following three actions:

> *the suspension, revocation, or cancellation of a CDL by the state or jurisdiction of issuance;*
>
> *any withdrawal of a person's privileges to drive a commercial motor vehicle by a state or other jurisdiction as a result of a violation of state or*

local law relating to motor vehicle traffic control (other than parking, vehicle weight or vehicle defect violations);

a determination by FMCSA that a person is not qualified to operate a commercial motor vehicle under 49 CFR 391 (October 1, 2012). [625 ILCS 5/1-115.3]

"Disseminating Agency" − an agency authorized by the Secretary of State to distribute or share an image received from the Secretary of State for purposes of secondary dissemination.

"Drive" − operate or be in physical control of a motor vehicle [625 ILCS 5/4-115.8].

"Driver" – every person who drives or is in actual physical control of a vehicle [625 ILCS 5/1-116].

"Driver Applicant" – a person applying to obtain, transfer, upgrade or renew a CDL.

"Driver's License Test" − a test administered by the Secretary of State that consists of a vision test, written test and/or road test.

"Driver's License Issuance Error" – any act or omission by a Secretary of State employee that results in the driver being not qualified to hold the license as it is classified, restricted and/or endorsed.

"Driver's License Record" – a file maintained by the Secretary of State on each driver in Illinois pursuant to IVC Section 6-117.

"Driver Rehabilitation Specialist" − a person who possesses an undergraduate degree in rehabilitation, education, health, safety, therapy or related profession (or equivalent of eight years of experience in driver rehabilitation); possesses a current Association of Driver Educators for the Disabled (ADED) Certification as a Driver Rehabilitation Specialist (consisting of successful completion of 100 clock hours of educational experience, in combination with safety and medical aspects of disabilities; a minimum of 30 hours must be gained from attending ADED approved courses or workshops).

"Driver Remedial Education Course" – an organized remedial activity approved by the Driver Services Department for improving the driving habits of certain suspended drivers. The course shall consist of individual counseling and/or group sessions of instruction and shall not exceed two sessions or a total of nine hours of instruction.

"Driver Services Facility" – the offices located throughout Illinois for the purpose of issuing driver's licenses and providing to the public other necessary services connected with the Secretary of State's Office.

"Driver Services Facility Representative" – an employee of the Department of Driver Services of the Office of Secretary of State.

"Driving Abstract" − a record kept by the Department of Driver Services containing all information required under IVC Section 6-106(b) and all records of violations of traffic laws and administrative actions pertaining to driving privileges.

"Driving Evaluation" – an assessment by a driver education specialist at a rehabilitation institution of an applicant's ability to safely operate a motor vehicle.

"Driving Skills" – the ability of an applicant to perform maneuvers to be demonstrated during a road test.

"Employer" – any individual, corporation, partnership or association that employs charter bus drivers licensed under IVC Section 6-508.

"Employer Certification" – a form submitted by the employer, as prescribed by the Secretary of State, certifying an applicant has met all conditions for application, or that a driver who is no longer eligible for a charter bus driver endorsement has been removed from service.

"Endorsement" – an indication on a driver's license that the driver has qualified to operate certain types and/or combinations of vehicles, and/or carry specified cargo.

"Enrolled in a Driver Education Course" – active participation in, and the 30 days immediately preceding, the start of regularly scheduled classroom instruction of an approved driver education course.

"Examiner" – an employee of the Secretary of State who is qualified to administer all driver's license tests.

"Excepted Interstate" or "EI" – a person who operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR 390.3(f), 391.2, 391.69 or 398.3 (October 1, 2012) *from all or part of the qualification requirements of 49 CFR 391* (October 1, 2012) *and is not required to obtain a medical examiner's certificate by 49 CFR 391.45* (October 1, 2012). [625 ILCS 5/6-500(15.3)]

"Excepted Intrastate" or "EA" – a person who operates in intrastate commerce but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements. [625 ILCS 5/6-500 (15.5)]

"Facility-Administered Road Test" – an actual demonstration of the applicant's ability to exercise ordinary and reasonable control of the operation of a motor vehicle administered by a Driver Services Facility employee.

"Farm" − structures and lands used primarily for the raising of agricultural or horticultural commodities, including livestock, poultry, fur-bearing animals, fruit, vegetables, flowers and other plants; "farm" includes ranches, nurseries, greenhouses, orchards, etc.

"Farm Retail Outlet and/or Supplier" – any individual, partnership, corporation or association engaged in a business operation for the purpose of selling or distributing agricultural commodities.

"Favorable Medical Report" − a current medical report that has been completed in its entirety and does not require additional information and/or clarification or is not medically questionable. A favorable medical report specifies a professional opinion from the competent medical specialist that the driver is medically/ mentally fit to safely operate a motor vehicle.

"Favorable Vision Specialist Report" – a current vision specialist report that has been completed in its entirety that does not require additional information and/or clarification.

"Federal Motor Carrier Safety Administration" or "FMCSA" − a separate administration within the U. S. Department of Transportation dedicated to improving the safety of commercial motor vehicles and saving lives.

"Felony" – an offense under state or federal law that is punishable by death or imprisonment for a term of one year or more.

"Final Determination of Threat Assessment" – a final administrative determination by TSA, including the resolution of related appeals, that an individual poses a security threat warranting denial of a Hazardous Material Endorsement.

"Fingerprint Process" – a method by which an applicant's fingerprints are taken for the purpose of a criminal background investigation for a charter bus driver endorsement and submitted to the Illinois Department of State Police (ISP) and the Federal Bureau of Investigation (FBI).

"First Division Vehicle" – any motor vehicle designed to carry not more than 10 persons [625 ILCS 5/1-217].

"Foreign Jurisdiction" – a sovereign jurisdiction that does not fall within the definition of "state" [625 ILCS 5/6-500(B)(17)].

"Foreign National" – a non-citizen of the United States of America who has been granted temporary, legal entry into this country by the U.S. Citizenship and Immigration Services (USCIS), who is temporarily residing in this State and is ineligible to obtain a social security number through the Social Security Administration, and who is not required to obtain a driver's license issued by the U.S. Department of State, Office of Foreign Missions.

"Foreign Speaking Applicant" – any applicant unable to understand oral directions given by the examiner.

"For-Profit Ridesharing Arrangement" – the transportation by motor vehicle of not more than 16 persons, including the driver, for which a fee is charged in accordance with Section 6 of the Ride Sharing Arrangements Act [625 ILCS 30/6]. [625 ILCS 5/1-122.7]

"Fraud" – includes anything calculated to deceive, whether it be a single act or combination of circumstances, whether the suppression of truth or the suggestion of what is false, whether it be by direct falsehood or by innuendo, by speech or by silence.

"Functional Ability" – the degree of cognitive, mental or emotional sensor motor, and sensory capability in performing activities of daily living, including safely performing driving tasks.

"Good Cause" − examples of dangerous driving or of a physical or mental condition that interferes with safe driving or a situation in which a Secretary of State Driver Services Facility supervisor fails to give a required test or section of a test.

"Gross Combination Weight Rating" or "GCWR" – the value specified by the manufacturer as the loaded weight of a combination (articulated) vehicle. In the absence of a value specified by the manufacturer, GCWR will be determined by adding the GVWR of the power unit and the total weight of the towed unit and any load thereon as specified in 49 CFR 383.5 (October 1, 2012). [625 ILCS 5/1-124.5]

"Gross Vehicle Weight Rating" or "GVWR" – the value specified by the manufacturer or manufacturers as the maximum loaded weight of a single vehicle. The GVWR of a combination of vehicles (commonly referred to as the "Gross Combination Weight Rating" or "GCWR") is the GVWR of the power unit plus the GVWR of the towed unit or units. In the absence of a value specified by the manufacturer, GCWR is determined by adding the GVWR of the power unit and the total weight of the towed unit and any load on the unit [625 ILCS 5/1-124.5].

"Hazardous Material Endorsement" or "HME" – an indicator on the driver's license that the driver is qualified to transport hazardous materials that require placarding.

"Hazardous Materials" – any material that has been designated as hazardous under 49 USC 5103 and is required to be placarded under subpart F of 49 CFR 172 (October 1, 2012) or any quantity of a material listed as a select agent or toxin in 42 CFR 73 (October 1, 2012).

"High School Student" – a student who attends a public or private secondary school accredited by the Illinois State Board of Education.

"Illinois Medical Advisory Board" or "Board" − a panel consisting of at least nine physicians appointed by the Secretary [625 ILCS 5/6-902].

"Illinois Vehicle Code" or "Vehicle Code" or "IVC" – 625 ILCS 5.

"Image" - the digital photo and signature captured in the process of issuing an Illinois driver's license or identification card and retrieved from the Secretary of State database.

"Immediate Family Member" – a parent, child, sibling, grandparent, step-parent, step-child, step-sibling or step-grandparent.

"Immediate Farm Family Member" − a member of the farmer's family is a natural or in-law, spouse, child, parent or sibling as provided in IVC Section 6-507(c).

"Incomplete Medical Report" − a medical report that has not been completed in its entirety, or a medical agreement that has not been signed and dated by the driver.

"Incomplete Telescopic Lens Vision Specialist Report" − a telescopic lens vision specialist report that has not been completed in its entirety. Examples of an incomplete report include, but are not limited to, omission of name, address, signature or professional license number of the vision specialist or date or one that contains illegible information or fails to answer any of the questions contained within the report.

"Initial Determination of Threat Assessment" – an initial administrative determination by TSA that an individual poses or may pose a security threat warranting denial of a Hazardous Material Endorsement.

"In Loco Parentis" – a person who is acting in place of a minor's parent with a parent's rights, duties and authority.

"Instruction Permit" – a driving permit issued to operate a motor vehicle pursuant to the requirements of IVC Section 6-105 or 6-107.

"Invalidate" – to render invalid any driver's license, permit or driving privileges.

"Invalidation" – the withdrawal, by consent, court order, death of the holder or holder's failure to complete a driver remedial education course of the validation, of a person's license, permit and/or driving privilege under IVC Chapter 6.

"Judicial Driving Permit" – a permit issued granting a driver limited driving privileges as provided in IVC Section 6-206.1.

"Law Enforcement Official" – a federal, state or local police officer, sheriff, coroner, municipal prosecutor, state's attorney or U.S. attorney.

"LEADS" − the Illinois Law Enforcement Agencies Data System.

"Livestock" – any animals such as cattle, sheep, swine, buffalo, cafalo, cattalo, domestic deer, domestic elk, domestic antelope, domestic reindeer, water buffalo and goats.

"Livestock Feeder" – any individual, partnership, corporation or association engaged in a business operation for the purpose of producing livestock.

"Mandatory Insurance" – The insurance requirements under IVC Chapter 7, Article VI.

"Mandatory Liability Insurance Policy" – a liability insurance policy issued in amounts no less than the minimum amounts set for bodily injury or death and for destruction of property (see IVC Section 7-203), and issued in accordance with the requirements of Sections 143a and 143a-2 of the Illinois Insurance Code [215 ILCS 5/143a and 143a-2]. This definition does not include vehicles subject to the provisions of IVC Chapter 18 or 18a, Article III or IVC Section 7-609, 12-607 or 12-707.01; vehicles required to file proof of liability insurance with the Illinois Commerce Commission; vehicles covered by a certificate of self-insurance (see IVC Section 7-502); vehicles owned by the United States Government, State of Illinois or any political subdivision, municipality or local mass transit district; implements of husbandry (see IVC Section 1-130), other vehicles complying with laws that require insurance in amounts meeting or exceeding the minimum amounts required under the IVC; and inoperable or stored vehicles that are not operated.

"Mandatory Law Enforcement Report" – an unsigned message directed to the Department electronically from law enforcement containing the same information as the form designed by the Department.

"Mechanical Aid" – a device added to a motor vehicle that would enhance the operator's ability to safely operate the vehicle.

"Medical Agreement" – an agreement signed and dated by the driver, maintained as part of the medical report, and including the following conditions and/or information:

a condition that the driver remain under the care of his/her competent medical specialist;

a condition that the driver adhere to the treatment and/or medication;

authorization by the driver to the competent medical specialist to report any change in the driver's condition that would impair the driver's ability to operate a motor vehicle;

possible consequences for failing to abide by any or all of the conditions contained in the medical agreement.

"Medical Examiner" – a person who is licensed, certified, or registered in accordance with applicable state laws and regulations to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced practice nurses, and doctors of chiropractic. [625 ILCS 5/6-500(21.1)]

"Medical Examiner's Certificate" – a document prescribed or approved by the Secretary of State that is issued by a medical examiner to a driver to medically qualify him or her to drive. [625 ILCS 5/6-500(21.2)]

"Medical Exemption" – temporary regulatory relief for up to two years from one or more Federal Motor Carrier Safety Regulations given to a person, by FMCSA, subject to the regulations, or a person who intends to engage in an activity that would be subject to the regulations in accordance with 49 CFR 381.300 (October 1, 2012).

"Medical Professional" – a person licensed under the Medical Practice Act [225 ILCS 60], or similar law of another jurisdiction, a physician assistant who has been delegated the authority to make the required determination by his or her supervising physician, or an advanced practice nurse who has a written collaborative agreement with a collaborating physician that authorizes the advanced practice nurse to make the determination.

"Medical Report" – a confidential medical questionnaire directed to the Department and approved by the Illinois Medical Advisory Board, or a statement on letterhead made by a competent medical specialist containing the same information as the form designed by the Department.

"Medical Restriction Card" – a card designed and issued by the Department that describes and explains the limitations and/or conditions noted in the restriction area of a person's driver's license.

"Medical Waiver" – temporary regulatory relief for up to three months from one or more Federal Motor Carrier Safety Regulations given to a person, by FMCSA, subject to the regulations, or a person who intends to engage in an activity that would be subject to the regulations in accordance with 49 CFR 381.200 (October 1, 2012).

"Medical Variance" – a driver has received one of the following from FMCSA, which allows the driver to be issued a medical certificate:

> *an exemption letter permitting operation of a CMV pursuant to 49 CFR 381* (October 1, 2012)*, subpart C or 49 CFR 391.64* (October 1, 2012)*; or*
>
> *a skilled performance evaluation (SPE) certificate permitting operation of a CMV pursuant to 49 CFR 391.49* (October 1, 2012). [625 ILCS 5/6-500 (21.5)]

"Mental or Physical Disorder or Disability" – a scientifically recognized condition that may medically impair a person's mental and/or physical health to the extent of being unable to safely operate a motor vehicle.

"Military Deferral Card" – a card issued at the expiration of the driver's license to extend the expiration while in the military, of the license of the licensee, spouse

and dependent children who are living with the licensee while on active duty serving in the Armed Forces of the United States outside the State of Illinois.

"Minor" – a person under 18 years of age.

"Miscellaneous Suspension" – a suspension for safety responsibility, financial responsibility, warrant parking/traffic, auto emissions, failure to appear, curfew, mandatory conviction, tollway, family financial responsibility, automated traffic law violation, nighttime driving restriction or unsatisfied judgement.

"Monocular Vision Acuity" – a visual acuity reading obtained utilizing each individual eye.

"Moped" − a motor-driven cycle, with or without optional power derived from manually operated pedals, whose speed attainable in one mile is at least 20 m.p.h. but not greater than 30 m.p.h., and is equipped with a motor that produces 2 brake horsepower or less. If an internal combustion engine is used, the displacement shall not exceed 50 cubic centimeter displacement and the power drive system shall not require the operator to shift gears. [625 ILCS 5/1-148.2]

"Motorcycle" – every motor vehicle having a seat or saddle for use of the rider and designed to travel on not more than three wheels in contact with the ground, but excluding a tractor [625 ILCS 5/1-147].

"Motorcycle Rider Safety Training Course" – a course of instruction in the use and operation of motorcycles and/or motor-driven cycles, including instruction in the safe on-road operation of motorcycles and/or motor-driven cycles, the rules of the road and the laws of this State relating to motor vehicles, which course must meet the requirements set out in 92 Ill. Adm. Code 455.101.

"Motor-Driven Cycle" − every motorcycle and every motor scooter with less than 150 cubic centimeter piston displacement, including motorized pedalcycles [625 ILCS 5/1-145.001].

"Motor Vehicle" – every vehicle that is self-propelled and every vehicle that is propelled by electric power obtained from overhead trolley wires, but not operated upon rails, except for vehicles moved solely by human power and motorized wheelchairs. Motor vehicles are divided into two divisions:

First Division: Those motor vehicles that are designed for the carrying of not more than 10 persons.

Second Division: Those motor vehicles that are designed for carrying more than 10 persons, those motor vehicles designed or used for living quarters, those motor vehicles that are designed for pulling or carrying freight, cargo or implements of husbandry, and those motor vehicles of the First Division remodeled for use and used as motor vehicles of the Second Division. [625 ILCS 5/1-146]

"Motor Vehicle Departments of Foreign States" – the departments in other states that issue driver's licenses.

"Motor Vehicle Record" – a report of the driving status and history of a driver generated from the driver record provided to users, such as drivers or employers, and is subject to the provisions of the Driver Privacy Protection Act (18 USC 2721-2725). [625 ILCS 5/6-500(22.2)]

"Nasal Vision Reading" – a field of vision 35º from the straight ahead.

"National Driver Register" or "NDR" – a computerized database of files on drivers maintained by the U.S. Department of Transportation, National Highway Traffic Safety Administration.

"Night" − the hours during the period from sunset to sunrise.

"Nighttime Drive" – a road test administered during the hours of sunset to sunrise.

"Nighttime Driving Privilege" – a privilege granted to a licensed driver to operate a motor vehicle during nighttime hours while wearing a telescopic lens arrangement.

"Non-CDL Skills Test" – any drive test given to an applicant who is attempting to obtain a driver's license except for a Class D, a CDL or a CDL endorsement.

"Non-Excepted Interstate" or "NI" – a person who operates or expects to operate in interstate commerce, is subject to and meets the qualification requirements under 49 CFR 391 (October 1, 2012)*, and is required to obtain a medical*

examiner's certificate by 49 CFR 391.45 (October 1, 2012). [625 ILCS 5/6-500(22.7)]

"Non-Excepted Intrastate" or "NA" – a person who operates only in intrastate commerce and is subject to State driver qualification requirements. [625 ILCS 5/6-500(22.8)]

"Official Investigation" – the act of examining and inquiring into an occurrence or circumstance with care and accuracy by a duly authorized member of a local, state or federal agency while acting in his/her professional capacity.

"Operator's License" – any driver's license to operate a motor vehicle issued under the laws of any state.

"Organized Religion" – a group of people with the same or similar beliefs brought together to exercise those beliefs.

"P Endorsement" – a notation on the driver's license that the driver has qualified to operate a vehicle designed to transport 16 or more persons, including the driver.

"Peripheral Vision" – vision from the outside line of direct sight toward the temporal area.

"Preliminary Favorable Medical Report" – a current medical report or a current written statement on official letterhead that is signed and dated by a competent medical specialist indicating in his/her professional opinion the driver is medically fit to safely operate a motor vehicle; however, additional information and/or clarification or consultation is needed.

"Probationary License" – a special license granting full driving privileges during a period of suspension and is issued upon successful completion of a driver remedial education course.

"Problem Driver Pointer System" or "PDPS" – a pointer file consisting of an index of problem drivers (as determined by adverse driver's license actions) that is maintained by a driver's home state (SOR) and is accessed by other states (SOI) to determine a person's eligibility to apply for a driver's license.

"Proof of Insurance" − acceptable forms of proof of insurance include, but are not limited to, the following:

Illinois insurance card that contains the company name, policy number, effective and expiration dates, name of the insured, vehicle year and make and a minimum of the last six characters of the Vehicle Identification Number (VIN);

Combination of proof of purchase of the motor vehicle within 60 days and a current insurance card [625 ILCS 5/7-602(b)];

Current declaration page of a liability policy [625 ILCS 5/7-602(c)] that contains the company name, policy number, effective and expiration dates, name of the insured, vehicle description and liability limits of the policy;

Liability insurance binder [625 ILCS 5/7-602(d)];

Certificate of Insurance [625 ILCS 5/7-602(d)];

Payment receipt for a liability insurance premium [625 ILCS 5/7-602(d)] that contains the company name, policy number, effective and expiration dates, name of the insured, vehicle year, make and a minimum of the last six characters of the VIN, date of premium payment and signature of company representative;

Current rental agreement [625 ILCS 5/7-602(e)];

Registration plates, registration sticker or other evidence of registration issued by the Secretary of State's Office only upon submission of proof of liability insurance [625 ILCS 5/7-602(f)];

Certificate, decal or other document or device issued by a governmental agency for a motor vehicle indicating the vehicle is insured for liability [625 ILCS 5/7-602(g)] (or has qualified for an exemption to the liability insurance law).

"Prosthesis" – an artificial limb such as arm or leg.

"Public Safety Worker" − a person employed by this State or a political subdivision thereof that provides firefighting, medical or other emergency services [625 ILCS 5/6-117.2(f)].

"Questionable Medical Report" – a medical report that contains medical information raising some reasonable doubt regarding the driver's medical ability to safely operate a motor vehicle, including the following:

A medical report that indicates the driver has experienced an attack of unconsciousness within the past six months;

The medical report lacks a professional opinion indicating whether the driver is medically fit to safely operate a motor vehicle;

The medical report was signed and/or completed by someone other than a competent medical specialist;

The competent medical specialist recommends the driver has driving privileges, however, expresses reservations about the driver's ability to safely operate a motor vehicle.

"Reckless Driving" – driving a motor vehicle with a willful or wanton disregard for the safety of persons or property or knowingly driving a vehicle using an incline in a roadway, such as a railroad crossing, bridge approach or hill to cause the vehicle to become airborne [625 ILCS 5/11-503].

"Registration Sticker" − a device or devices to be attached to a rear registration plate that will renew the registration and registration plate or plates for a pre-determined period not to exceed one registration year except as provided in IVC Section 3-414(1).

"Regularly Scheduled Classroom Instruction" – the continuous and uninterrupted education course that takes place during the specific time period (i.e., quarter) in which the school has scheduled the student to participate.

"Rehabilitation Institution" – any hospital, center, institute or facility engaged in a program to provide driver training for the disabled.

"Religious Organization Bus" – any vehicle other than a vehicle of the First Division or a school bus as defined by IVC Section 1-182 that is exclusively owned and operated by a religious organization and is used primarily in conducting the official activities of that organization.

"Religious Organization Vehicle Restriction" – the authority to operate a religious organization bus (see IVC Section 6-106.2).

"Representative Vehicle" – a motor vehicle that represents the type an applicant operates or expects to operate.

"Rescind" – to annul or void a suspension, revocation, cancellation, disqualification or denial.

"Restricted Local License" – a special restricted driver's license issued under IVC Section 6-113 and intended to enable a person to drive a specific route.

"Restriction" – the notation on a driver's license or permit indicating requirements deemed applicable to the licensee by the Department to assure safe operation of a motor vehicle.

"Review of Driving Habits" – a review of the applicant's driving record maintained by the Office of the Secretary of State, or documentation from another licensing entity, that has been certified within 30 days prior to the date of application, to insure that the requirements are met (see IVC Sections 6-104, 6-508).

"Road Test" – an actual demonstration of the applicant's ability to operate a motor vehicle (see IVC Section 6-109).

"S Endorsement" − an endorsement for CDL holders who operate as a school bus driver to transport pre-primary, primary or secondary school students to and from home, from school to home, or to and from school-sponsored events.

"Safety Course" – an explanation provided by a rental agency to an individual during the rental transaction concerning the controls and features of the vehicle and its proper operation.

"Safety Officer" – any individual employed by a third-party certifying entity who is licensed for the purpose of conducting the skills test to determine for certification purposes that an applicant has been tested and meets the same qualifications required by the Secretary of State.

"SAVE" − the Systematic Alien Verification for Entitlements Program that allows electronic inquiries to U.S. Citizenship and Immigration Services (USCIS) by state motor vehicle agencies in the determination of the immigration status of an applicant for a Visa Status Temporary Visitor's Driver's License pursuant to IVC Section 6-105.1(a).

"School Bus" – every motor vehicle, except as provided in this definition, owned or operated by or for any of the following entities for the transportation of persons regularly enrolled as students in grade 12 or below in connection with any activity of the entity:

Any public or private primary or secondary school;

Any primary or secondary school operated by a religious institution; or

Any public, private or religious nursery school.

This definition shall not include the following:

A bus operated by a public utility, municipal corporation or common carrier authorized to conduct local or interurban transportation of passengers when the bus is not traveling a specific school bus route but is:

On a regularly scheduled route for the transportation of other fare paying passengers;

Furnishing charter service for the transportation of groups on field trips or other special trips or in connection with other special events; or

Being used for shuttle service between attendance centers or other education facilities.

A motor vehicle of the first division.

A motor vehicle designed for the transportation of not less than seven nor more than 16 persons that is operated by or for a public or private primary or secondary school, including any primary or secondary school operated by a religious institution, for the purpose of transporting not more than 15 students to and from interscholastic athletic or other interscholastic or school sponsored activities. [625 ILCS 5/1-182]

"School Bus Commercial Instruction Permit " or "School Bus CIP" – an instruction permit that allows an applicant for a school bus permit to operate a school bus, but only when accompanied by a properly classified driver with a school bus permit.

"School Bus CDL Restriction" – a "J48" restriction placed on a commercial driver's license or school bus commercial instruction permit, which limits commercial motor vehicle operation to a school bus only, within classification, valid only when accompanied by a valid Illinois school bus permit.

"School Bus Driver Permit" – a permit issued to an applicant who has met all the requirements that authorize the individual to drive a school bus (see IVC Section 6-106.1).

"Seasonal Restricted Commercial Driver's License" or "Restricted CDL" – a limited waiver for employees of certain farm-related services to operate specific commercial motor vehicles without a commercial driver's license for a limited period.

"Second Division Vehicle" – any vehicle designed to carry more than 10 persons, those designed or used for living quarters and those vehicles designed to pull or carry property, freight or cargo, those motor vehicles of the first division remodeled for use and used as motor vehicles of the second division, and those motor vehicles of the first division used and registered as school buses [625 ILCS 5/1-217].

"Secondary Dissemination" – the distributing or sharing of an image by a source other than the primary source (Secretary of State) that has direct access to the image.

"Secretary of State" – the Secretary of State of Illinois [625 ILCS 5/1-184].

"Self-Admission" – a statement or indication from the driver that he/she has a mental disorder/disability and/or physical condition or disability that may impair the ability to safely operate a motor vehicle or that is likely to cause a loss of consciousness.

"Self-Certification" – a driver's signed and dated declaration of the type of driving (NI, EI, NA, EA) in which he or she engages or expects to engage while operating a CMV.

"Senior Citizen Transportation Vehicle" – a vehicle, other than a vehicle of the first division or a school bus, exclusively owned and operated by a senior citizen organization and used primarily in conducting the official activities of the organization.

"Serious Traffic Violation" – a conviction when operating a commercial motor vehicle, or when operating a non-CMV, while holding a CDL of: a violation relating to excessive speeding involving a single speeding charge of 15 miles per hour or more above the legal speed limit; a violation relating to reckless driving; a violation of any State law or local ordinance relating to motor vehicle traffic control (other than parking violations) arising in connection with a fatal traffic accident; a violation, relating to having multiple driver's licenses (see IVC Section 6-501); a violation relating to the requirement to have a valid CDL (see IVC Section 6-507(a)); a violation relating to improper or erratic lane changes; a violation relating to following another vehicle too closely; any other similar violation of a law or local ordinance of any state relating to motor vehicle traffic control, other than a parking violation, which the Secretary of State determines to be relevant pursuant to 92 Ill. Adm. Code 1040.20.

"Skills Performance Evaluation" or "SPE" – a certificate, issued by FMCSA to a driver with a missing limb, in accordance with 49 CFR 391.49 (2011), which allows the driver to operate a CMV.

"Special Needs Individuals" – those individuals who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required be individuals generally [625 ILCS 5/6-117.2(f).

"SSOLV" − the Social Security Online Verification system that allows electronic inquiries to the Social Security Administration by state motor vehicle agencies to verify names and social security numbers of applicants for driver's licenses or identification cards.

"State" – a state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a province of the Dominion of Canada [625 ILCS 5/1-195].

"Suspension" – the temporary withdrawal by formal action of the Secretary of a person's license or privilege to operate a motor vehicle on the public highways, for a period specifically designated by the Secretary [625 ILCS 5/1-204].

"Tank Vehicle" – any commercial motor vehicle that is designed to transport any liquid or gaseous material within a tank that is either permanently or temporarily attached to the vehicle or the chassis. Those vehicles include, but are not limited to, cargo tanks and portable tanks, as defined in 49 CFR 171 (2011). [625 ILCS 5/1-204.4] However, a tanker-type vehicle does not include any vehicle in which the tank, that is either permanently or temporarily attached, has a rated capacity of less than 1,000 gallons.

"Telescopic Lens Arrangement" – a non-standard adaptive device that aids in improving vision deficits.

"Telescopic Lens Vision Specialist Report" – an approved confidential vision questionnaire directed to the Department, or a statement on letterhead made by a vision specialist, containing the same information as the form designed by the Department.

"Temporal Vision Reading" – a field of vision 70º from the straight ahead.

"Temporary Driver's License or Instruction Permit" – a driver's license or instruction permit issued for no longer than 90 days to a person who is temporarily unable to obtain a license or instruction permit.

"Temporary Visitor's Driver's License" or "TVDL" – a license issued to:

a foreign national who is authorized to temporarily reside in this country allowing the operation of a motor vehicle under the laws of this State

(referred to in this Part as "Visa status"); or

an applicant who:

resided in this State for a period in excess of one year;

is ineligible to obtain a social security number; and

is unable to present documentation issued by the United States Citizenship and Immigration Services authorizing the person's presence in this country [625 ILCS 5/6-105.1(a-5)] referred to in this Part as "non-Visa status".

"Termination of an Adjudication of Disability Order" – an order by a court of competent jurisdiction terminating an adjudication of disability of the driver pursuant to Section 11a-20 of the Probate Act of 1975 [755 ILCS 5/11a-20].

"Third-Party Certification License" − a license issued by the Secretary of State to conduct a qualified third-party certification program (see IVC Section 6-508).

"Third-Party Certification Program" − a program designed by the Secretary of State allowing third-party entities to provide to employees or by membership in a qualified training program of classroom and/or behind-the-wheel testing for the purpose of certifying to the Secretary of State that an applicant is qualified to operate a motor vehicle without the Secretary of State having to administer a road test (see IVC Section 6-508 and Section 1030.85).

"Third-Party Certifying Entity" − a third-party entity licensed by the Secretary of State to engage in a third-party certification program.

"Transportation Security Administration" or "TSA" – a division of the Department of Homeland Security administering provisions of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act (USA Patriot Act; Public Law 107-56, 115 Stat. 272).

"Traffic Regulation Governing the Movement of Vehicles" – a violation for which points are assigned pursuant to 92 Ill. Adm. Code 1040.20.

"Type A Injury" – an injury that requires immediate professional attention in either a doctor's office or a medical facility and includes severely bleeding wounds, distorted extremities and injuries requiring the injured party to be carried from the scene.

"Traffic Environmental Screening" – a screening designed by the Department that shall consist of the driver demonstrating the ability to recognize actual traffic conditions using the telescopic lens arrangement while riding with and being evaluated by a Driver Services Facility representative.

"Unfavorable Medical Report" – a medical report signed and completed by a competent medical specialist containing a professional opinion that, due to a physical and/or mental disorder/disability, the driver is not medically fit to operate a motor vehicle.

"Unfavorable Telescopic Lens Vision Specialist Report" – a telescopic lens vision specialist report signed and completed by a licensed vision specialist that indicates a professional opinion that the driver is not capable of safely operating a motor vehicle, or the monocular or binocular acuity readings and/or peripheral readings do not meet Illinois standards, or the peripheral vision readings do not meet Illinois standards as set forth in Section 1030.70, or the power of the telescopic lenses does not meet Illinois standards as set forth in Section 1030.75.

"Unfavorable Vision Specialist Report" – a vision specialist report signed and completed by a vision specialist indicating the monocular or binocular acuity and/or peripheral vision readings do not meet Illinois standards as set forth in Section 1030.70, the driver would not accept or has refused the recommended correction, and his/her vision readings without this correction are not favorable.

"Unfit to Stand Trial Order" – an order by a court of competent jurisdiction whereby a defendant, because of a mental or physical condition, is unable to understand the nature and purpose of the proceeding against him/her or to assist in his/her defense pursuant to Section 104-10 of the Code of Criminal Procedure [725 ILCS 5/Art. 104-10].

"USCIS" − U.S. Citizenship and Immigration Services is a bureau of the U.S. Department of Homeland Security (USDHS) that is in charge of processing immigrant visa petitions, naturalization petitions, and asylum and refugee

applications, as well as making adjudicative decisions performed at the services centers and managing all other immigration benefit functions.

"Valid Driver's License or Permit" – a license or permit issued by the Secretary of State that is of the proper classification for the purposes for which it is being used and that has not expired, been invalidated, denied, canceled, revoked, suspended or disqualified, or been used after a curfew or nighttime driving restriction.

"Vendor" – an authorized fingerprint company approved by the ISP who will transmit fingerprint data to ISP to be forwarded to the FBI.

"Verification of Residency Form" – a form printed by the Secretary of State that non-Visa status temporary visitor's driver's license applicants shall complete and that contains all Illinois addresses at which the applicant has resided for the 12 months immediately prior to application.

"Vision Screening" – the readings obtained by a physician, ophthalmologist, optometrist or Department representative of an applicant's visual acuity and peripheral fields of vision.

"Vision Specialist" – a doctor licensed to practice medicine in optometry under the Illinois Optometric Practice Act [225 ILCS 80] or a competent medical specialist.

"Vision Specialist Report" – an approved confidential vision questionnaire directed to the Department, or a statement on letterhead made by a vision specialist, containing the same information as the form designed by the Department.

"Visual Acuity Readings" – the minimum vision standards set forth in Sections 1030.70 and 1030.75.

"Visual Peripheral Readings" – the minimum vision standards set forth in Sections 1030.70 and 1030.75.

"Withdrawal" – the negating of valid driving privileges by a state as the result of sanctions taken against driving privileges.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1030.5 Procedure for Obtaining a Driver's License

a) A person who wishes to obtain a driver's license shall go to one of the Secretary of State Driver Services Facilities located throughout the State. An application form provided by the Secretary of State pursuant to IVC Section 6-106 shall be completed by the applicant. The questions contained on the application form are provided in Appendix A. The applicant shall also provide a Driver Services Facility employee with acceptable forms of identification provided in Appendix B establishing the applicant's name, date of birth, signature for comparison, Illinois residency and social security number.

b) The applicant shall take the following tests as required in IVC Section 6-109:

1) A vision test as provided in Sections 1030.70 and 1030.75;

2) A road test, if required, as provided in Section 1030.85 (exemptions to the road test requirement are provided in Section 1030.88); and

3) A written test, if required, as provided in Section 1030.80.

c) Applicants who are 16 or 17 years of age and not legally emancipated by marriage shall not be issued a driver's license without the written consent of the applicant's parent, legal guardian or other responsible adult, regardless of whether the required written consent also accompanied the person's previous application for an instruction permit and until the applicant has, in accordance with IVC Section 6-107(b):

1) Held a valid instruction permit for a minimum of 9 months;

2) Passed an approved driver education course and submitted proof of having passed the course as may be required;

3) Submitted, on a form prepared or approved by the Secretary of State, certification by the parent of the applicant, the legal guardian having custody of the applicant, or, in the event there is no parent or legal guardian, by another responsible adult, that the applicant has had a minimum of 50 hours, at least 10 hours of which have been at night, of behind-the-wheel practice time and is sufficiently prepared and able to

safely operate a motor vehicle. The 50 hours shall be in addition to the required hours spent with a driver education instructor. The person completing the certification shall, upon signing the certification, swear under penalty of perjury, that everything contained within the certification is true and correct.

d) Applicants who are 18, 19 or 20 years of age who have not previously been licensed and who have not successfully completed an approved driver education course or the classroom portion of an approved driver education course shall not be issued a driver's license unless the applicant has successfully completed an adult driver education course offered by an adult driver education course provider and proof of that completion has been submitted to the Secretary by the adult driver education course provider.

e)~~d)~~ A driver's license applicant shall have his/her photograph taken unless exempted by Section 1030.90. A driver's license shall be issued upon completion of all the requirements of this Section and IVC Chapter 6.

f)~~e)~~ The fees collected for the issuance of an original, renewal, duplicate or corrected driver's license shall be in accordance with IVC Section 6-118.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1030.6 Procedure for Obtaining a Visa Status Temporary Visitor's Driver's License Pursuant to IVC Section 6-105.1(a)

a) Any foreign national who wishes to obtain a temporary visitor's driver's license (TVDL), pursuant to IVC Section 6-105.1(a), shall go to one of the designated TVDL Secretary of State Driver Services Facilities located throughout the State. An application form, provided by the Secretary of State pursuant to IVC Section 6-106, shall be completed by the applicant. The questions contained on the application form are provided in Appendix A. The applicant shall also provide a Driver Services Facility employee with acceptable forms of identification described in Appendix B to establish the applicant's name, date of birth, signature for comparison, Illinois temporary residency, and authorization of legal presence in this country. The applicant shall also provide a government-issued photo identification document and documentation from the Social Security Administration verifying ineligibility for a social security number.

b) A TVDL shall only be issued to an individual who is authorized to reside in this country for one or more years and has at least six months of authorized presence remaining at the time of application. Individuals currently holding a TVDL who have been granted a temporary extension to remain in this country pending a decision on a request for a status change, upon presentation of documents issued by USCIS, may be issued a TVDL for the period of the temporary extension.

c) The applicant shall take the following tests as required in IVC Section 6-109:

1) A vision test as provided in Sections 1030.70 and 1030.75;

2) A road test, if required, as provided in Section 1030.85 (exemptions to the road test requirement are provided in Section 1030.88); and

3) A written test, if required, as provided in Section 1030.80.

d) Applicants who are 16 or 17 years of age and not legally emancipated by marriage shall not be issued a TVDL without the written consent of the applicant's parent, legal guardian or other responsible adult, regardless of whether the required written consent also accompanied the person's previous application for an instruction permit and, in accordance with IVC Section 6-107(b), the applicant has:

1) Held a valid instruction permit for a minimum of 9 months;

2) Passed an approved driver education course and submitted proof of having passed the course as may be required;

3) Submitted, on a form prepared or approved by the Secretary of State, certification by the parent of the applicant, the legal guardian having custody of the applicant, or, in the event there is no parent or legal guardian, by another responsible adult, that the applicant has had a minimum of 50 hours, at least 10 hours of which have been at night, of behind-the-wheel practice time and is sufficiently prepared and able to safely operate a motor vehicle. The 50 hours shall be in addition to the required hours spent with a driver education instructor. The person completing the certification shall, upon signing the certification, swear under penalty of perjury that everything contained within the certification is true and correct.

e) Applicants who are 18, 19 or 20 years of age who have not previously been licensed and who have not successfully completed an approved driver education course or the classroom portion of an approved driver education course shall not be issued a driver's license unless the applicant has successfully completed an adult driver education course offered by an adult driver education course provider and proof of that completion has been submitted to the Secretary by the adult driver education course provider.

f)~~e)~~ A TVDL applicant shall have his/her photograph taken, unless exempted by Section 1030.90.

g)~~f)~~ A TVDL shall only be issued in Class D, L or M, as established in Section 1030.30.

h)~~g)~~ A TVDL shall not be issued to the applicant at the Secretary of State Driver Services facility, but shall be centrally issued and mailed to the applicant at the address provided on the TVDL application. A dated receipt shall be issued to the applicant.

i)~~h)~~ Each original TVDL shall expire 3 years from the date of issuance or at the time the individual's authorization to remain in this country expires, whichever is earlier. Except, the TVDL of an individual 81 years of age or older shall expire in accordance with IVC Section 6-115(g) or at the time the individual's authorization to remain in this country expires, whichever is earlier.

j)~~i)~~ Each renewal TVDL shall expire no more than 3 years from the expiration date of the current license or at the time the individual's authorization to remain in this country expires, whichever is earlier. Except, the TVDL of an individual 81 years of age or older shall expire in accordance with IVC Section 6-115(g) or at the time the individual's authorization to remain in this country expires, whichever is earlier.

k~~j)~~ The fees collected for the issuance of an original, renewal, duplicate or corrected TVDL shall be in accordance with IVC Section 6-118.

l)~~k)~~ Any person who wishes to renew a TVDL shall go to one of the designated Secretary of State Driver Services Facilities located throughout the State no more than 90 days prior to the expiration date of the current TVDL. An applicant for

renewal shall comply with the provisions of subsection (a) of this Section. The applicant shall also be retested in accordance with IVC Section 6-109.

m)~~l)~~ The Secretary of State shall not send a renewal notice to the holder of a TVDL.

n)~~m)~~ The design and content of a TVDL shall be in accordance with IVC Sections 6-105.1 and 6-110 and Section 1030.90. The license shall be distinctive in nature to identify it as a TVDL and shall contain the phrase "not valid for identification".

o)~~n)~~ Each TVDL issued to applicants under 21 years of age shall be in accordance with IVC Sections 6-107.3 and 6-110(e) and (e-1). A TVDL issued to an individual under the age of 21 years shall expire 3 years from the issue date or at the time the individual's authorization to remain in this country expires, whichever is earlier.

p)~~o)~~ A foreign national who is issued a TVDL shall not be required to surrender his/her foreign country driver's license.

q)~~p)~~ A Central Unit will be established within the Driver Services Department. The responsibilities of this Central Unit shall be to provide assistance to Driver Services Facility employees responsible for the issuance of a TVDL and to individuals applying for a TVDL; resolve cases in which the USCIS was unable to provide first level verification of USCIS documents, via the Systematic Alien Verification for Entitlements (SAVE) Program, presented by TVDL applicants at the Driver Services Facility level; perform liaison services to USCIS; and provide written notification of an applicant's eligibility or ineligibility for a TVDL.

1) When an applicant appears at one of the designated Driver Services Facilities and provides the necessary documents to prove identity and legal presence, a facility employee will begin the process by initiating an automated inquiry via the SAVE Program to verify the information on the USCIS documents. Upon receipt of a verification response from the SAVE Program, the facility employee will begin the TVDL application process. If the facility employee receives the response of "initiate additional verification", additional information is submitted to USCIS via the SAVE Program and copies of the applicant's documents are forwarded to the Central Unit for monitoring. The applicant will be advised that he or she will receive written notification from the Central Unit regarding his or her eligibility for a TVDL.

2) A response to a second request for verification of USCIS documents via the SAVE Program generally takes 3 to 5 days. Upon receipt of a response from the second verification request via the SAVE Program, the Central Unit will send a letter to the applicant informing the applicant of eligibility or ineligibility for a TVDL.

3) If the Central Unit receives a response of "Need Copies of Docs" from USCIS via the SAVE Program, a third, manual verification process must be completed. This requires photocopies of the documents submitted for identification, accompanied by a USCIS G-845 Form (request for verification of documentation of alien status), to be forwarded to USCIS in Chicago, Illinois. Upon receipt of a written response from USCIS, the Central Unit will send a letter to the applicant informing the individual of eligibility or ineligibility for a TVDL.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1030.7 Procedure for Obtaining a Non-Visa Status Temporary Visitor's Driver's License Pursuant to IVC Section 6-105.1(a-5)

a) An applicant who wishes to obtain an original TVDL, renew a TVDL, or obtain a corrected TVDL, pursuant to IVC Section 6-105.1(a-5), must make an appointment, via telephone or the Secretary of State's official website, to visit one of the designated TVDL Secretary of State Driver Services Facilities located throughout the State. At a later date, the Secretary of State, based on the operational needs of the office, may eliminate the requirement for appointments. An applicant who wishes to obtain a duplicate TVDL shall visit any TVDL facility located throughout the State. An application form, provided by the Secretary of State pursuant to IVC Section 6-106, shall be completed by the applicant. The questions contained on the application form are provided in Appendix A.

b) An applicant for an original, renewal, duplicate or corrected TVDL shall provide acceptable forms of identification as defined in Appendix C to establish the applicant's name, date of birth, signature for comparison, current Illinois residence address, and residency in Illinois for a period in excess of one year. The applicant shall affirm under penalty of perjury that he/she is ineligible to obtain a social security number and shall submit either a valid, unexpired passport for the applicant's country of citizenship or a valid, unexpired consular identification

document, as defined by Section 5 of the Consular Identification Document Act [5 ILCS 230/5], issued by the consulate of the applicant's country of citizenship and, if a new applicant, must submit a completed verification of residency form.

c) The applicant shall take the following tests as required in IVC Section 6-109:

1) A vision test as provided in Sections 1030.70 and 1030.75;

2) A road test, if required, as provided in Section 1030.85 (exemptions to the road test requirement are provided in Section 1030.88); and

3) A written test, if required, as provided in Section 1030.80.

d) Applicants who are 16 or 17 years of age and not legally emancipated by marriage shall not be issued a TVDL without the written consent of the applicant's parent, legal guardian or other responsible adult, regardless of whether the required written consent also accompanied the person's previous application for an instruction permit and, in accordance with IVC Section 6-107(b), the applicant has:

1) Held a valid instruction permit for a minimum of 9 months;

2) Passed an approved driver education course and submitted proof of having passed the course as may be required;

3) Submitted, on a form prepared or approved by the Secretary of State, certification by the parent of the applicant, the legal guardian having custody of the applicant, or, in the event there is no parent or legal guardian, by another responsible adult, that the applicant has had a minimum of 50 hours, at least 10 hours of which have been at night, of behind-the-wheel practice time and is sufficiently prepared and able to safely operate a motor vehicle. The 50 hours shall be in addition to the required hours spent with a driver education instructor. The person completing the certification shall, upon signing the certification, swear under penalty of perjury that everything contained within the certification is true and correct.

e) Applicants who are 18, 19 or 20 years of age who have not previously been licensed and who have not successfully completed an approved driver education

course or the classroom portion of an approved driver education course shall not be issued a driver's license unless the applicant has successfully completed an adult driver education course offered by an adult driver education course provider and proof of that completion has been submitted to the Secretary by the adult driver education course provider.

f)~~e)~~ A TVDL applicant shall have his/her photograph taken, unless exempted by Section 1030.90.

g)~~f)~~ A TVDL shall only be issued in Class D, L or M, as established in Section 1030.30.

h)~~g)~~ A TVDL shall not be issued to the applicant at the Secretary of State Driver Services facility, but shall be centrally issued and mailed to the applicant at the address provided on the TVDL application. A dated receipt shall be issued to the applicant.

i)~~h)~~ Each original TVDL shall expire 3 years from the date of issuance, except that a TVDL issued to an applicant 81 years of age or older shall expire in accordance with IVC Section 6-115(g).

j~~i)~~ An applicant for a renewal TVDL shall be retested in accordance with IVC Section 6-109.

k)~~j)~~ Each renewal TVDL shall expire no more than 3 years from the expiration date of the current license, except that a TVDL issued to an applicant 81 years of age or older shall expire in accordance with IVC Section 6-115(g).

l)~~k)~~ The Secretary of State shall not send a renewal notice to the holder of a TVDL.

m)~~l)~~ The design and content of a TVDL shall be in accordance with IVC Sections 6-105.1 and 6-110 and Section 1030.90. The license shall be distinctive in nature to identify it as a TVDL and shall contain the phrase "not valid for identification".

n)~~m)~~ The design and content of a TVDL issued to applicants under 21 years of age shall be in accordance with IVC Sections 6-107.3 and 6-110(e) and (e-1).

o)~~n)~~ The fees collected for the issuance of an original, renewal, duplicate or corrected TVDL shall be in accordance with IVC Section 6-118.

p)~~o)~~ An applicant for a TVDL that is male and is between the ages of 18 and 25 is not exempt from the requirement to register with the United States Selective Service System, in accordance with IVC Section 6-106.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1030.65 Instruction Permits

a) A person who wishes to practice driving before obtaining a driver's license shall obtain an instruction permit from a Driver Services Facility.

b) Any foreign national who wishes to practice driving before obtaining a Visa status, temporary visitor's driver's license pursuant to IVC Section 6-105.1(a) shall obtain a temporary visitor's instruction permit from one of the selected Driver Services Facilities located throughout the State.

c) Any person over the age of 18 or any person under the age of 18 who is enrolled in driver education at a commercial driver training school regulated by the Secretary of State who wishes to practice driving before obtaining a non-Visa status temporary visitor's driver's license pursuant to IVC Section 6-105.1(a-5) shall make an appointment, via telephone or the Secretary of State's official website, to visit one of the designated TVDL Secretary of State Driver Services Facilities located throughout the State to obtain a temporary visitor's instruction permit. An application form, provided by the Secretary of State pursuant to IVC Section 6-106, shall be completed by the applicant. The questions contained on the application form are provided in Appendix A. An applicant for a non-Visa status temporary visitor's instruction permit shall provide acceptable forms of identification as provided in Appendix C to establish the applicant's name, date of birth, signature for comparison, current Illinois residence address and residency in Illinois for a period in excess of one year. The applicant shall also submit a completed Verification of Residency form and either a valid, unexpired passport for the applicant's country of citizenship or a valid, unexpired consular identification document, as defined by Section 5 of the Consular Identification Document Act [5 ILCS 230/5], issued by the consulate of the applicant's country of citizenship and shall be required to submit a verification of residency form. Applicants over the age of 18 must also affirm under penalty of perjury that they are ineligible to obtain a social security number.

d) Any person under the age of 18 enrolled in an approved driver education course at a public high school who wishes to practice driving before obtaining a non-Visa status temporary visitor's driver's license shall complete an application form, provided by the Secretary of State pursuant to IVC Section 6-106. The questions contained on the application form are provided in Appendix A. The applicant will be required to submit the acceptable forms of identification, as defined in Appendix C, at the time of application for a non-Visa status TVDL for a driver's license at a Driver Services Facility.

e) Upon receipt of an instruction permit or temporary visitor's instruction permit, the holder may operate a motor vehicle upon the highways of this State when accompanied by an adult instructor of a driver education program or when practicing with a parent, legal guardian, family member or person in loco parentis who is 21 years of age or more and has a license classification to operate the vehicle and at least one year of driving experience, and is occupying a seat beside the driver.

f) A temporary visitor's instruction permit shall only be issued in a Class D, L or M as established in Section 1030.30.

g) The fees collected for the issuance of an original, renewal, duplicate or corrected instruction permit or temporary visitor's instruction permit shall be in accordance with IVC Section 6-118(a).

h) A minor who wishes to receive an instruction permit shall be at least 15 years old and enrolled in a driver education course. Any minor who has been enrolled in an approved driver education program out-of-state shall provide proof of that enrollment before an Illinois instruction permit will be issued. Proof shall consist of a letter from the minor's school on the school's letterhead or other proof deemed acceptable by the Secretary of State. The minor shall complete a driver education course prior to applying for a driver's license before the minor is 18 years of age. If the minor is 16 years of age or older and possesses a certificate of completion or the equivalent from another state's driver education program, the minor shall be eligible to receive an Illinois driver's license upon successful completion of the vision, written and/or road tests. The equivalent of an Illinois certificate of completion from an out-of-state driver education course shall include, but is not limited to, transcripts from the out-of-state attendance center indicating successful completion of the course of instruction or a letter from the state's driver's licensing authority on agency letterhead, attesting to the minor's

successful completion of a driver education course approved by the office that regulates education.

i) A minor who is at least 15 years and 6 months of age may obtain an Illinois instruction permit prior to being enrolled in a driver education course, provided the minor:

1) Submits written documentation, on a form prepared or approved by the Secretary of State, stating that the minor is enrolled in school; meets the educational requirements of the Driver Education Act [105 ILCS 5/27-24 through 27-24.8] and IVC Section 6-103(1) and signed by a superintendent or chief administrator that states, through no fault of the minor, the minor will be unable to be enrolled in a driver education course until after the minor's 16th birthday and the school would have no objection to the issuance of the instruction permit; and

2) Successfully completes the written and vision examinations administered either by an approved driver education instructor or the Secretary of State.

j) An instruction permit issued to a minor under subsection (i) may be canceled upon receipt of a report from the minor's school on the school letterhead, or other proof deemed acceptable by the Secretary of State, stating the minor has failed to enroll in a driver education course.

k) The minor who is not legally emancipated by marriage or court order shall have the application signed by a parent, guardian or person in loco parentis and the driver education instructor. The minor shall then be allowed to take the vision and written exams.

l) The instruction permit shall be issued to a minor for a period of 24 months upon successful completion of the written and vision exams. If an instruction permit has expired prior to the applicant completing the road test, a second fee established for instruction permits in IVC Section 6-118(a) must be submitted and the written and vision exams must be successfully completed. The applicant shall present another application to the Secretary of State signed by the parent, guardian or person in loco parentis. The driver education instructor shall also sign the application unless the applicant presents a certificate of completion.

m) An Illinois instruction permit issued to a minor may be canceled if the student is certified as a chronic or habitual truant or has dropped out of school. The report shall be received from the Illinois State Board of Education in a form acceptable to the Secretary of State.

n) Applicants who are not minors shall also be issued instruction permits by the Secretary of State. The permit shall be issued for 12 months upon successful completion of the written and vision exams.

o) Applicants whose driving privileges have been canceled based upon receipt by the Department of a medical report indicating the applicant has a medical condition that impairs the applicant's ability to safely operate a motor vehicle may apply for an instruction permit. The Department shall receive a favorable medical report from a competent medical specialist describing the applicant's needs to undergo a driving evaluation with a driver rehabilitation specialist. The Department shall issue to the applicant an authorization for examination to appear at a Driver Services Facility to take the written test and vision test and submit the fee required by IVC Section 6-118(a). Upon successful completion of the written and vision tests, the applicant shall be issued, if not otherwise prohibited, an instruction permit that shall be canceled upon receipt of a written statement from a competent medical specialist that the instruction permit holder has failed to successfully complete the driving evaluation or is otherwise unable to safely operate a motor vehicle. A medical restriction card shall be issued by the Department and must be carried with the instruction permit. Upon successful completion of the driving evaluation, the rehabilitation institution and a competent medical specialist shall notify the Department. The Department shall send the applicant an authorization form instructing the applicant to appear at a Driver Services Facility to take the drive portion of the test. Upon the applicant's successful completion of the drive examination, a driver license shall be issued.

p) An applicant must be at least 16 years old to obtain a Class L instruction permit and must possess a certificate of completion at the time of application.

q) A Class M instruction permit may be issued by the Secretary of State to an applicant 18 or older for a period of 12 months. A Class M instruction permit may be issued for a period of 24 months to applicants 16 or 17 years old who have obtained a certificate of completion at the time of application and have completed a motorcycle training course approved by the Illinois Department of Transportation (see 92 Ill. Adm. Code 455). A certificate of completion card

issued by the Illinois Department of Transportation must be furnished to the Secretary of State's Office before an instruction permit will be issued.

r) An applicant who is 17 years and 3 months of age or older may obtain an Illinois instruction permit without being enrolled in a driver education course, provided the applicant has successfully completed the vision and written exams.

s) An applicant 18, 19 or 20 years of age may obtain an Illinois instruction permit without being enrolled in an adult driver education course.

t)~~s)~~ Prior to renewing a commercial driver instruction permit, an applicant is required to successfully complete the appropriate CDL knowledge tests specific to the classification of permit being renewed.

u)~~t)~~ Prior to renewing a non-commercial instruction permit, an applicant is required to successfully complete vision screening and a written test.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1030.66 Adult Driver Education

a) A person age 18, 19 or 20 who wishes to apply for an Illinois driver's license and who has not previously held a driver's license or who has not successfully completed an approved driver education course or the classroom portion of an approved driver education course must successfully complete an adult driver education course offered by a certified adult driver education course provider.

b) A list of certified adult driver education providers is available at the Illinois Secretary of State official website (www.cyberdriveillinois.com).

c) To receive credit for participation in an adult driver education course, the applicant must take the course only from a provider that has been certified by the Secretary.

d) Applicants who take an adult driver education course from an entity that is not certified to provide adult driver education in Illinois shall not be issued an Illinois driver's license until the applicant successfully completes an adult driver education course from a certified provider, or until the applicant turns 21 years of age.

e) Upon receipt of notification from a provider that a student has successfully completed the adult driver education course, the Secretary shall send the applicant a notification, which the student shall bring to a Secretary of State facility to complete the application process for the issuance of a driver's license in accordance with this Part.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Commercial Driver Training Schools

2) Code Citation: 92 Ill. Adm. Code 1060

3)

Section Numbers:	Proposed Action:
1060.5	Amend
1060.71	New
1060.72	New

4) Statutory Authority: 625 ILCS 5/6-107.5

5) A Complete Description of the Subjects and Issues Involved: This rulemaking will implement PA 98-167, effective July 1, 2014 that requires driver's license applicants between the ages of 18 and 20 who have never previously been licensed or completed an approved driver education course to complete six hour of adult driver education.

The rule sets forth requirements for existing licensed commercial driver training schools to offer the adult education program, in either a classroom or online setting. The rule also set forth requirements for those entities that are not currently licensed as commercial driver training schools to obtain certification to offer online-only adult driver education. Requirements for online providers include submission of an application, a fingerprint-based background check, surety bond, approval by the Secretary of the proposed course content and verification of student participation and identity.

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

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

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

9) Does this rulemaking contain incorporations by reference? No

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

11) Statement of Statewide Policy Objective: The rulemaking will not create or enlarge a State mandate.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Text of the prepared amendments is posted on the Secretary of State's website, www.sos.il.us/departments/index/home as part of the *Illinois Register*. Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after publication of this Notice to:

Jennifer Egizii
Office of the Secretary of State
Driver Services Department
2701 South Dirksen Parkway
Springfield IL 62723

217/557-4462

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Existing commercial driver training schools and new entities wishing to offer adult driver education, either in a classroom or online setting

B) Reporting, bookkeeping or other procedures required for compliance: Applicants will be required to complete an application to offer adult driver education and undergo a fingerprint-based background check and maintain a continuous surety bond. Once certified, providers will be required to maintain records of student enrollment, attendance and completion and will be required to report enrollment and completion to the Secretary of State.

C) Types of Professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2014

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

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1060
COMMERCIAL DRIVER TRAINING SCHOOLS

Section
1060.5 Definitions
1060.10 Unlicensed Person May Not Operate Driver Training School
1060.20 Requirements for School Licenses
1060.30 Driver Training School Names
1060.40 Refund of Application Fees
1060.50 School Locations and Facilities
1060.60 Driver Training School Student Instruction Record
1060.70 Driver Training School Course of Instruction
1060.71 Adult Driver Education Course Certification
1060.72 Adult Driver Education Classroom Instruction
1060.80 Driver Training School Contracts
1060.90 Inspection of School Facilities
1060.100 Licenses
1060.110 Safety Inspection of Driver Training School Motor Vehicles
1060.120 Requirements to Obtain and Retain a Driver Training Instructor's License
1060.130 Examination for Driver Training Instructor
1060.140 Temporary Permit
1060.150 Driver Training School Responsibility for Employees
1060.160 Solicitation of Students and Pupils for Commercial Driver Training Instruction
1060.170 Hearings
1060.180 Teen Accreditation
1060.181 Teen Accreditation Classroom and Behind-the-Wheel Requirements
1060.190 Denial, Cancellation, Suspension, and Revocation of Commercial Driver Training School's License, Teen Accreditation, CDL Accreditation, and Instructor's License
1060.200 Commercial Driver's License and/or Endorsement and/or Accreditation
1060.210 Driver Training School Responsibility for Employees (Recodified)
1060.220 Solicitation of Students and Pupils for Commercial Driver Training Instruction (Recodified)
1060.230 Hearings (Recodified)
1060.240 Teen Accreditation (Recodified)

1060.250 Denial, Cancellation, Suspension, and Revocation of Commercial Driver Training School's License and Instructor's License (Recodified)
1060.260 Commercial Driver's License and/or Endorsement and/or Restriction Accreditation (Recodified)

AUTHORITY: Implementing Article IV of the Illinois Driver Licensing Law of the Illinois Motor Vehicle Code [625 ILCS 5/Ch. 6, Art. IV] and authorized by Section 2-104(b) of the Illinois Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed March 2, 1972; codified at 6 Ill. Reg. 12697; transferred from 23 Ill. Adm. Code 252.50 (State Board of Education) pursuant to Section 5-80(d) of the Illinois Administrative Procedure Act [5 ILCS 100/5-80(d)] and Section 6-411 of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/6-411] at 11 Ill. Reg. 1631, effective December 31, 1986; amended at 11 Ill. Reg. 17244, effective October 13, 1987; amended at 12 Ill. Reg. 13203, effective August 1, 1988; amended at 12 Ill. Reg. 19756, effective November 15, 1988; amended at 14 Ill. Reg. 8658, effective May 18, 1990; recodified at 17 Ill. Reg. 20006, effective November 3, 1993; amended at 18 Ill. Reg. 7788, effective May 9, 1994; amended at 20 Ill. Reg. 3861, effective February 14, 1996; amended at 22 Ill. Reg. 22069, effective December 2, 1998; emergency amendment at 24 Ill. Reg. 8403, effective June 2, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15443, effective October 5, 2000; amended at 25 Ill. Reg. 6409, effective April 26, 2001; amended at 26 Ill. Reg. 15020, effective October 1, 2002; emergency amendment at 28 Ill. Reg. 398, effective December 22, 2003, for a maximum of 150 days; emergency expired May 19, 2004; amended at 28 Ill. Reg. 11925, effective July 26, 2004; amended at 30 Ill. Reg. 11377, effective June 14, 2006; amended at 31 Ill. Reg. 16008, effective November 16, 2007; amended at 33 Ill. Reg. 15811, effective October 27, 2009; amended at 34 Ill. Reg. 19099, effective November 22, 2010; amended at 37 Ill. Reg. 4295, effective March 20, 2013; amended at 37 Ill. Reg. 18893, effective November 5, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 1060.5 Definitions

For purposes of this Part, the following definitions shall apply:

"Administrator" − any individual who is employed by or acts on behalf of a high school who administers a State approved high school driver education program.

"Adult Driver Education Course" − a six hour classroom or online course of driver education for persons ages 18, 19 or 20 offered by an adult driver education course provider.

"Adult Driver Education Course Provider" or "Provider" − an entity certified by the Secretary of State to provide an adult driver education course in a classroom setting, which also may be certified to offer an adult driver education course online.

"Branch Office" – an office of a commercial driver training school in a distinct location from the main office, but that conducts business under the name and as a part of the school as provided in IVC Article IV and that meets the requirements of Section 1060.50.

"Business Day" – any day that the Office of the Secretary of State Commercial Driver School Division is open, i.e., Monday through Saturday, excluding State holidays.

"Cancellation" – the without prejudice annulment or termination by formal action of the Secretary of a driver training school's license or a driver training school instructor's license because of some error or defect in the license or because the licensee is in some form of violation of any of the requirements in the Illinois Vehicle Code or Illinois Administrative Code. The annulment or termination shall not be subject to renewal or restoration, except that an application for a new license shall be presented and acted upon by the Secretary after the licensee demonstrates compliance with the provisions of this Part for which the cancellation was issued.

"CDL Accreditation" – the accreditation of a commercial driver training school by the Department that allows the school to offer instruction to students who wish to obtain a CDL and/or endorsement.

"CDL Study Guide" – a study guide, compiled by the Secretary of State from information contained in the Illinois Vehicle Code and 49 CFR 383, that is designed to aid drivers in preparing for a CDL examination.

"Commercial Driver's License" or "CDL" − a license issued by a state or other jurisdiction, in accordance with the standards contained in 49 CFR 383 (2008;

this incorporation includes no later amendments or editions)*, to an individual, which authorizes the individual to operate a certain class of commercial motor vehicle as defined in IVC Section 1-111.6.*

"Commercial Driver Training School" – an entity licensed by the Secretary of State to engage in the business of giving instruction for a fee in the driving of motor vehicles or in the preparation of an applicant for examination given by the Secretary of State for a driver's license or permit.

"Commercial Driver Training Section" – a unit of the Department of Driver Services that oversees the licensing of commercial driving schools and the instructors in commercial driver training schools.

"Commercial Motor Vehicle" or "CMV" – a motor vehicle used in commerce, except those referred to in Section 6-500(6)(B) of the Illinois Vehicle Code, designed to transport passengers or property if:

the vehicle has a Gross Vehicle Weight Rating (GVWR) of 26,001 pounds or more or such a lesser GVWR as subsequently determined by federal regulations (49 CFR 383 (2008)); or

any combination of vehicles with a Gross Combination Weight Rating (GCWR) of 26,001 pounds or more, provided the GVWR of any vehicle or vehicles being towed is 10,001 pounds or more; or

the vehicle is designed to transport 16 more persons; or

the vehicle is transporting hazardous materials and is required to be placarded in accordance with 49 CFR 172, subpart F (2008). [625 ILCS 5/6-500].

"Department" – Department of Driver Services within the Office of the Secretary of State.

"Endorsement" – an indication on the driver's license that the driver has qualified to operate certain types and/or combinations of vehicles, and/or carry specified cargo.

"Enhanced Instruction Report" – a report submitted on a form prescribed by the Department showing the name, address, and number of behind-the-wheel instruction periods taken for every student who has had 25 hours of behind-the-wheel instruction.

"Fraud" – includes anything calculated to deceive, whether it be a single act or combination of circumstances, whether the suppression of truth or the suggestion of what is false, whether it be by direct falsehood or by innuendo, by speech or by silence.

"Gross Vehicle Weight Rating" or "GVWR" – the value specified by the manufacturer or manufacturers as the maximum loaded weight of a single vehicle. The GVWR of a combination of vehicles (commonly referred to as the "Gross Combination Weight Rating" or "GCWR") is the GVWR of the power unit plus the GVWR of the towed unit or units. In the absence of a value specified by the manufacturer, GCWR is determined by adding the GVWR of the power unit and the total weight of the towed unit and any load on the unit. [625 ILCS 5/1-124.5]

"Hazardous Materials" – any material that has been designated as hazardous under 49 USC 5103 and is required to be placarded under subpart F of 49 CFR 172 (2008) or any quantity of a material listed as a select agent or toxin in 42 CFR 73 (2008).

"Illinois Vehicle Code" or "Vehicle Code" or "IVC" − 625 ILCS 5.

"Instruction Record" – records kept by the instructor to reflect the number of hours a pupil in a commercial driver training school attends behind-the-wheel and classroom instruction as provided in IVC Section 6-418.

"Main Office" – the primary office of the commercial driver training school that is designed solely for conducting the business of the school as provided in Article IV of the Illinois Driver Licensing Law of the Illinois Vehicle Code.

"Misrepresentation" – a false statement of a substantive fact, or any conduct that leads to a belief of a substantive fact material to proper understanding of the matter in hand, made with intent to deceive or mislead.

"Physical Facilities" – the building and items that constitute part of the building, including the telephone and the furniture.

"Questionnaires" − any and all written examinations and/or forms, including but not limited to the "Illinois Driver's License Written Examination Basic and Classification "D"" and "Identification of Signs, Shapes and Colors" forms.

"Restriction" – the notation on a driver's license or permit indicating requirements deemed applicable to the licensee by the Department to assure safe operation of a motor vehicle.

"Revocation" – the termination by formal action of the Secretary of a commercial driver training school's license or a commercial driver training school instructor's license. The termination shall be subject to renewal or restoration identical to the provisions for revocation of a driver's license as provided in IVC Section 1-176.

"Sex and Drug Related Offenses" – offenses of criminal sexual assault [720 ILCS 5/12-13], aggravated criminal sexual assault [720 ILCS 5/12-14], criminal sexual abuse [720 ILCS 5/12-15], aggravated criminal sexual abuse [720 ILCS 5/12-16], juvenile pimping [720 ILCS 5/11-19.1], soliciting for a juvenile prostitute [720 ILCS 5/11-15.1], unauthorized manufacture or delivery of a controlled substance, including counterfeit drugs [720 ILCS 570/401], sale, delivery or exchange of instruments used for illegal drug use or abuse [720 ILCS 5/22-51], delivery of a controlled substance, including counterfeit and look alike substances [720 ILCS 570/407], manufacture or delivery of cannabis [720 ILCS 550/5], delivery of cannabis [720 ILCS 550/7], the production of the cannabis plant [720 ILCS 550/8], illegal possession in a motor vehicle of any controlled substance or any cannabis [625 ILCS 5/6-206(a)(28)], the criminal transmission of HIV [720 ILCS 5/12-16.2], exploitation of a child [720 ILCS 5/11-19.2], controlled substance trafficking [720 ILCS 570/401.17], cannabis trafficking [720 ILCS 550/5.1], delivery of cannabis on school grounds [720 ILCS 550/5.2], calculated criminal cannabis conspiracy [720 ILCS 550/9], calculated criminal drug conspiracy [720 ILCS 570/405], and criminal drug conspiracy [720 ILCS 570/405.1].

"Short Review Course" − a course offered by commercial driver training schools to pupils who have previously held or currently hold a valid driver's license and that does not meet the requirement of 6 hours of classroom instruction and 6 hours behind-the-wheel instruction.

"Surety Bond" – a written obligation whereby a person assumes liability for another person's debts or defaults of obligation.

"Suspension" – the procedures for temporary withdrawal of a commercial driver training school's license or commercial driver training school instructor's license identical to the provisions for the suspension of a driver's license as provided in IVC Section 1-204.

"Teen Accreditation" – the accreditation of a commercial driver training school by the Department that allows the school to offer instruction to pupils under age 18.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1060.71 Adult Driver Education Course Certification

a) Certification of Provider – Any entity that desires to offer an adult driver education course in a classroom setting, as provided in Section 6-107.5 of the IVC, must be licensed as a commercial driver training school and be certified as an adult driver education provider by the Secretary of State through the Department before instruction can be offered or advertised. Any entity that is licensed as a commercial driver training school and is accredited to provide teen instruction shall be certified to offer adult driver education.

1) Upon receipt of a Secretary of State application to provide adult driver education, the Secretary of State shall investigate the applicant and verify the information contained in the application. A Secretary of State employee shall contact the applicant and make an appointment to inspect the applicant's proposed classroom facilities. At the time of inspection, the Secretary of State employee shall verify that the applicant meets the standards for adult driver education course certification set forth in this Section, in addition to all other applicable Sections within this Part. Upon request, these standards shall be furnished to the applicant by the Secretary of State before the visit. If all qualifications and standards are met, the applicant shall be certified to offer the adult driver education course.

2) Certification is renewable upon the expiration date of the commercial driver training school license, provided all qualifications and standards are met and the commercial driver training school has been and is in compliance with this Part.

3) Only qualified personnel who hold a valid commercial driver training school instructor license may teach the adult driver education course.

4) Prior to certification, providers must submit a copy of their adult driver education course content to the Commercial Driver Training School Section for review and approval, including the questions and answers on the final examination.

5) Providers must utilize only the approved course content, which shall be enforced by the Secretary by unannounced inspections of the provider's classroom facilities.

6) If a provider wishes to substantially change its course content, a copy of the proposed course content must be submitted to the Commercial Driver Training School Section for review and approval.

7) Providers must monitor the Illinois General Assembly and update their course content to include any new laws regarding the rules of the road or operation of motor vehicles. This update shall be submitted to the Commercial Driver Training School Section for review and approval within 60 days after the effective date of the law change.

b) Required Facilities – All adult driver education course providers, except those providers that offer adult driver education solely through an online course must provide classroom facilities prescribed in IVC Sections 6-406 and 6-407 and Section 1060.50 of this Part.

c) Required Course of Instruction:

1) Providers must provide 6 hours of classroom instruction in accordance with Section 1060.72.

2) Each student must complete the 6 hours of instruction within 30 days after commencement of the class.

3) Students must make up any class or portion of a class missed.

4) No more than 90 minutes of instruction may consist of video instruction.

5) Providers may use up to 60 minutes of simulators or other interactive modes of instruction.

6) No course may exceed 30 students unless the size of the classroom exceeds 350 square feet, in which case a maximum of 35 students is allowed.

7) At the commencement of instruction, the provider must give all students a copy of the current edition of the Illinois Rules of the Road.

8) Criteria for passing the course shall be provided to the student prior to the commencement of the course.

9) Each student shall be informed, prior to the collection of any fees and the time instruction begins, of the amount of any and all fees or charges relative to the adult driver education course, including but not limited to enrollment, tuition, equipment, textbooks and instructional materials.

10) Instruction shall take place at the dates, times and location designated by the school and agreed to by the student as specified on the Secretary of State enrollment form, unless the course is cancelled and the student is refunded any fees already paid, and each course shall have definitive start and completion dates.

11) Students must complete a final examination at the end of the course, which shall consist of 20 questions, from a test bank of 40 questions. Students shall not be deemed to have passed the course unless they score a minimum of 75% on the final examination. If a student scores less than 75%, the student shall be re-tested, using different questions from the test bank, at no additional charge or fee to the student. The student is not required to repeat the course, but may be allowed to review the course

materials prior to retaking the examination. If the student fails the comprehensive final examination 2 times, the student has failed the course.

d) Records documenting attendance and evaluation of each student shall be maintained by the provider. The records shall also contain the dates and length of time of classroom instruction. Students shall be identified by full name (first, middle and last), address, date of birth, gender and email address. Schools may not request the social security number of any student. The records shall be maintained in the office of the main location of the provider for a period of 3 years.

e) Within 2 business days after successful completion of an adult driver education course, providers shall electronically transmit to the Secretary the student's full name (first, middle and last), address, date of birth, gender and email address, accompanied by the statutory fee of $5.

f) Adult driver education course providers who are licensed as commercial driving training schools may also provide an online adult driver education course provided the school complies with the requirements of 92 Ill. Adm. Code 1066.

g) The Secretary of State shall suspend, revoke, cancel or deny the adult driver education course certification of any provider that fails to comply with any provision of this Part.

(Source: Added at 38 Ill. Reg. _____, effective _____)

Section 1060.72 Adult Driver Education Classroom Instruction

a) Course Objectives. The educational objectives of adult driver education shall include, but not be limited to, promoting respect for and encouraging observance of traffic laws and traffic safety responsibilities of drivers and citizens, reducing traffic violations, reducing traffic-related injuries, deaths and economic losses, and motivating continuing development of traffic related competencies through education, including, but not limited to, Illinois traffic law, risk management, driver attitudes, courtesy skills, and informing participants about the effects of alcohol and other drugs on driving ability.

b) Course Content
At a minimum, course content must include:

1) Familiarization with the process of obtaining an instruction permit and driver's license and the obligations and responsibilities that exist with holding a license;

2) Instruction on traffic laws;

3) Highway signs;

4) Signals and markings that regulate, warn or direct traffic, including traffic signs and lane markings;

5) Issues commonly associated with motor vehicle accidents, including poor decision making, risk taking, distractions, speed, failure to use a safety belt, driving at night, failure to yield the right-of-way, texting while driving and using wireless communication devices;

6) How to respond to emergency vehicles;

7) Turning, passing and yielding;

8) Construction and school zones;

9) Stopping distance;

10) Blind spots;

11) Strategy for driving using:

A) Smith System;

B) IPDE Process;

C) Zone Control;

D) Any other recognized process for identifying problems, predicting outcomes, deciding action and executing decisions;

12) Right-of-way for pedestrians, emergency vehicles and school buses;

13) Sharing the road with pedestrians, bicyclists, motorcyclists, trucks and recreational vehicles;

14) Road hazards, including visibility, weather and traction;

15) Mental conditions, including alertness, awareness and emotion;

16) Alcohol and other drugs, including effects, responsibilities, driving under the influence, zero tolerance, and implied consent laws;

17) Differences in urban and rural driving, including driving on highways and Interstate driving;

18) Organ donor; and

19) Illinois Secretary of State emergency contact database.

(Source Added at 38 Ill. Reg. _____, effective _____)

SECRETARY OF STATE

NOTICE OF PROPOSED RULES

a) Heading of the Part: Online Only Adult Driver Education Course Provider Certification

b) Code Citation: 92 Ill. Adm. Code 1066

c)

Section Number:	Proposed Action:
1066.5	New
1066.10	New
1066.20	New
1066.30	New
1066.40	New
1066.45	New
1066.50	New
1066.60	New
1066.70	New
1066.80	New
1066.90	New
1066.100	New

d) Statutory Authority: 625 ILCS 5/6-107.5

e) A Complete Description of the Subjects and Issues Involved: This rulemaking will implement PA 98-167, effective July 1, 2014 that requires driver's license applicant's between the ages of 18 and 20 who have never previously been licensed or completed an approved driver education course to complete six hour of adult driver education.

The rulemaking sets forth requirements for existing licensed commercial driver training schools to offer the adult education program, in either a classroom or online setting. The rulemakings also set forth requirements for those entities that are not currently licensed as commercial driver training schools to obtain certification to offer online-only adult driver education. Requirements for online providers include submission of an application, a fingerprint-based background check, surety bond, approval by the Secretary of the proposed course content and verification of student participation and identity.

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

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

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

9) Does this rulemaking contain incorporation by reference? No

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

11) Statement of Statewide Policy Objectives: The rulemaking will not create or enlarge a State mandate.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Text of the prepared amendments is posted on the Secretary of State's website, www.sos.il.us/departments/index/home as part of the Illinois Register. Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after publication of this Notice to:

Jennifer Egizii
Office of the Secretary of State
Driver Services Department
2701 South Dirksen Parkway
Springfield, IL 62723

217/557-4462

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Existing commercial driver training schools and new entities wishing to offer adult driver education, either in a classroom or online setting.

B) Reporting, bookkeeping or other procedures required for compliance: Applicants will be required to complete an application to offer adult driver education and undergo a fingerprint-based background check and maintain a continuous surety bond. Once certified, providers will be required to maintain records of student enrollment, attendance and completion and will be required to report enrollment and completion to the Secretary of State.

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2014

SECRETARY OF STATE

NOTICE OF PROPOSED RULES

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

SECRETARY OF STATE

NOTICE OF PROPOSED RULES

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1066
ONLINE ONLY ADULT DRIVER EDUCATION
COURSE PROVIDER CERTIFICATION

Section
1066.5 Definitions
1066.10 Certification Required
1066.20 Requirements for Online Only Adult Education Course Providers
1066.30 Online Only Adult Driver Education Course Provider Names
1066.40 Online Only Adult Driver Education Course Required Instruction
1066.45 Online Only Adult Driver Education Course Content
1066.50 Online Only Adult Driver Education Course Student Instruction Record
1066.60 Online Only Adult Driver Education Course Student Contracts
1066.70 Online Only Adult Driver Education Course Provider Verification of Student Identity and Course Completion
1066.80 Hearings
1066.90 Denial, Cancellation, Suspension and Revocation of an Online Only Adult Driver Education Course Provider Certification
1066.100 Online Only Adult Driver Education Course Website and Security Requirements

AUTHORITY: Implementing and authorized by Section 6-107.5 of the Illinois Driver Licensing Law [625 ILCS 5/6-107.5].

SOURCE: Adopted at 38 Ill. Reg._____, effective_____.

Section 1066.5 Definitions

Unless otherwise noted, the following definitions shall apply to this Part:

"Applicant" − an entity applying for certification as an online only adult driver education course provider. Every officer, owner, director, partner and/or manager is subject to this Part.

"Certification" – a document issued by the Department that authorizes the entity named in the document to offer an online only adult driver education course.

"Consumer Information" − name, address, date of birth, gender, email address and payment information, including credit card and bank account numbers or electronic payment data of students who are enrolled in or have completed an adult driver education course.

"Department" − the Commercial Driving Training School Division within the Department of Driver Services within the Office of the Secretary of State.

"Fraudulent Activity" – any action calculated to deceive, whether it be a single act or combination of circumstances, whether the suppression of the truth or the suggestion of what is false, whether it be by direct falsehood or by innuendo, by speech or by silence.

"Illinois Vehicle Code" or "Vehicle Code" or "IVC" − 625 ILCS 5.

"Online Only Adult Driver Education Course Provider" or "Provider" − an entity or person certified by the Secretary of State to provide an adult driver education course solely online.

"Secretary of State" or "Secretary" − the Secretary of State of the State of Illinois.

Section 1066.10 Certification Required

a) No person, firm, association, partnership or corporation shall operate as a provider or engage in the business of providing an online only adult driver education course unless a certification has been issued by the Secretary.

b) No provider may remain in operation if its certification to operate as a provider is suspended, revoked, canceled or not renewed.

Section 1066.20 Requirements for Online Only Adult Education Course Providers

a) The Secretary of State shall not issue, or shall deny, cancel, suspend or revoke, an online only adult education course provider certification:

1) Unless the applicant/provider is of good moral character. In making a determination of good moral character, the Department is not limited to, but may consider, the following:

A) Whether the applicant/provider has been convicted of a felony or a misdemeanor. The Department shall consider:

i) The relationship of any crime of which the applicant/provider has been convicted to the ability to operate an online only adult driver education course;

ii) The length of time that has elapsed since the applicant's/provider's last criminal conviction;

iii) Whether the applicant/provider successfully completed any sentence imposed with the convictions;

iv) Whether the applicant/provider has multiple convictions for felony or misdemeanor offenses.

B) If the person has been indicted, formally charged or otherwise charged with a felony or a misdemeanor, the certification shall be either denied or cancelled.

i) If the person whose certification has been denied or cancelled under this Part is adjudicated "guilty" by the court, the denial or cancellation previously entered on his/her record in accordance with this Section shall stand. This action does not preclude further suspension and/or revocation of the certification under another Section of this Part or the IVC.

ii) If the person whose certification has been denied or cancelled under this Part is adjudicated "not guilty" by the court, the denial or cancellation previously entered on his/her record in accordance with this Section shall be rescinded. This action does not preclude further suspension and/or revocation of the certification under another Section of this Part or the IVC.

iii) If the person whose certification has been denied or cancelled under this Part is granted a disposition of "court supervision" by the court, the denial or cancellation

previously entered on his/her record in accordance this with this Section shall be rescinded. This action does not preclude further suspension and/or revocation of the certification under another Section of this Part or the IVC.

2) Unless the applicant authorizes an investigation to include a fingerprint-based background check to determine if the applicant has ever been convicted of a crime and, if so, the disposition of those convictions. The authorization shall indicate the scope of the inquiry and the agencies that may be contacted. Upon this authorization, the Secretary of State may request and receive information and assistance from any federal, State or local governmental agency as part of the authorized investigation. Each applicant shall have his or her fingerprints submitted to the Department of State Police in the form and manner prescribed by the Department of State Police. The fingerprints shall be checked against the Department of State Police and Federal Bureau of Investigation criminal history record information databases. The applicant shall be required to pay all related fingerprint fees, including, but not limited to, the amounts established by the Department of State Police and the Federal Bureau of Investigation to process fingerprint-based criminal background investigations. The Department of State Police shall provide information concerning any criminal convictions and disposition of criminal convictions brought against the applicant upon request of the Secretary of State provided that the request is made in the form and manner required by the Department of State Police. Unless otherwise prohibited by law, the information derived from the investigation, including the source of the information and any conclusions or recommendations derived from the information by the Secretary of State, shall be provided to the applicant, or his or her designee, upon request to the Secretary of State, prior to any final action by the Secretary of State on the application. Any criminal convictions and disposition information obtained by the Secretary of State shall be confidential and may not be transmitted outside the Office of the Secretary of State, except as required in this Part, and may not be transmitted to anyone within the Office of the Secretary of State except as needed for the purpose of evaluating the applicant. At any administrative hearing held under IVC Section 2-118 relating to the denial, cancellation, suspension or revocation of a certification, the Secretary of State is authorized to utilize at that hearing any criminal histories, criminal convictions and disposition information obtained under this Section. The information obtained from

the investigation may be maintained by the Secretary of State or any agency to which the information was transmitted. Only information and standards that bear a reasonable and rational relationship to the performance of an online only adult education course shall be used by the Secretary of State.

3) To any owner or employee who, during the course of interaction with students:

A) Engaged in activity that puts the student in danger; or

B) Engaged in reckless behavior; or

C) Failed to maintain a professional relationship with students at all times.

4) Unless the applicant/provider files and maintains with the Department a continuous surety bond in the principal sum of $50,000, underwritten by a company authorized to do business in the State of Illinois, for the protection of the contractual rights of students. However, the aggregate liability of the surety for all breaches of the condition of the bond in no event shall exceed the principal sum of $50,000. The surety on any bond may cancel the bond on giving 30 days notice in writing to the Secretary of State and shall be relieved of liability for any breach of any conditions of the bond that occurs after the effective date of cancellation. All bonds filed pursuant to this provision shall be in substantially the following form:

Know All Persons by These Presents, That We, _____ _____, of _____, hereinafter referred to as Principal and _____, a corporation organized and existing to do business in the State of Illinois, for the use and benefit of all persons who may be damaged by breach of this bond, as Obligees, in the penal sum of $50,000, lawful money of the United States of America, for the payment of which sum, well and truly to be made, we bind ourselves, our executors, administrators, successors and assigns, firmly by these presents. The condition of this obligation is such that the principal has

made application to the Illinois Secretary of State for certification for the purpose of exercising the vocation of an online only adult education course provider. If the Principal faithfully complies with the Illinois Vehicle Code and all rules and regulations that have been or may hereafter be in force concerning the license or permit, and shall save and keep harmless the Obligees from all loss or damage that may be sustained as a result of the issuance of the license or permit to the Principal, this obligation shall be void; otherwise, this obligation shall remain in full force and effect. The bond will expire but may be continued by renewal certificate signed by Principal and Surety. The Surety may at any time terminate its liability by giving 30 days written notice to the Commercial Driver Training Section of the Department, 650 Roppolo Drive, Elk Grove Village, Illinois 60007, and the Surety shall not be liable for any default after that 30 day notice period, except for defaults occurring prior thereto.

Signed, Sealed and Dated this _____ day of _____ , 20__

Principal _____

Surety _____

By _____
Attorney-in-fact

5) Unless the Secretary is satisfied that the applicant/provider has established adequate procedures for verifying the identity of the student taking the course and ensuring that the student completes the course in its entirety.

6) Unless the applicant submits a copy of its course content, conforming with Section 1066.45, to the Department for review and approval, including the questions and answers on the quizzes and final examination.

7) If a provider fails to immediately report to the Department any unauthorized access to consumer information, including computer breaches, or fails to comply with the Illinois Personal Information Protection Act [815 ILCS 530/5].

8) If the applicant/provider is an Illinois corporation, unless the corporation is in good standing with the Illinois Secretary of State, Department of Business Services.

9) If the applicant/provider is a foreign corporation, unless the corporation is authorized to transact business in Illinois, as evidenced by submission of an Application for Authority to Transact Business in Illinois and acceptance of the same by the Illinois Secretary of State, Department of Business Services.

10) If the applicant/provider is a foreign limited liability company, unless the limited liability company is authorized to transact business in Illinois, as evidenced by submission of an Application for Admission to Transact Business and acceptance of that application by the Illinois Secretary of State, Department of Business Services.

11) If the owner or any employee of the applicant/provider is a current salaried or contractual employee of the Secretary of State.

12) If an applicant/provider, owner or manager engages in fraudulent activity as defined in Section 1066.5.

13) If an applicant, owner or employee has been declared to have engaged in fraudulent activity within the 5 years prior to making application for certification.

14) If an applicant/provider or owner owes outstanding fees to the Secretary of State.

15) If an applicant/provider sells or discloses any consumer information or fails to post a statement indicating consumer information will not be sold or disclosed on its website.

16) If an applicant/provider requests the social security number of students.

17) If a provider fails to immediately report to the Department any unauthorized access to consumer information, including computer breaches.

18) Unless the provider/applicant maintains a customer service telephone number staffed between 8:00 a.m. and 5:00 p.m. CST Monday through Friday and also maintains an email address or voice mail or answering

service 24 hours a day, 7 days a week. All inquiries must be resolved within 72 hours after first contact.

19) Unless the provider/applicant provides the Department with a detailed description of each position involved in every facet of the adult driver education course, with contact information for each employee. The provider must report any staffing changes to the Department within 72 hours after the change.

20) If the provider uses voice recognition as a method of verification, unless the provider furnishes a toll free number for the purposes of providing the required voice exemplars.

b) Only one provider certification shall be issued to any individual, group, association, partnership or corporation, and the Department shall deny an application for certification as a provider if any of the applicants are unqualified, are already certified or have made application as another provider.

c) Upon receipt of a properly executed application for certification, the Department shall investigate the qualifications of the applicant to determine whether the application should be granted or denied.

d) Certifications may only be issued by the Department.

e) An entity whose certification has been denied, cancelled, suspended or revoked pursuant to this Part may request an administrative hearing pursuant to 92 Ill. Adm. Code 1001.

f) All monies required to be remitted by a provider to the Department must be submitted in United States currency.

Section 1066.30 Online Only Adult Driver Education Course Provider Names

a) No provider shall adopt, use or conduct any business under a name that is not distinguishable upon the records of the Department from a name used by another provider, as distinguishable is defined in 14 Ill. Adm. Code 150.440.

b) No provider shall incorporate under its own or another name unless the name of the proposed corporation is submitted to the Department of Business Services of

the Office of the Secretary of State for a final determination of the availability of the name, along with the fee required by Section 15.10 of the Business Corporation Act of 1983 [805 ILCS 5/15.10].

c) No provider name shall contain, separate and apart from any other word or abbreviation in the name, the word "corporation", "company", "incorporated" or limited", or an abbreviation of one of these words, unless so licensed by the Secretary of State.

d) No provider shall operate under an assumed name, unless the provider complies with all provisions of the Assumed Business Name Act [805 ILCS 405].

e) No provider shall change its name unless 30 days prior written notice is given to the Department stating the change of name. Upon receipt of notice of name change, the Department shall, without an application fee, require the provider to complete an amended application for certification in the form and manner prescribed for original applicants.

Section 1066.40 Online Only Adult Driver Education Course Required Instruction

a) Providers must provide 6 hours of online driver education instruction in accordance with the course content set forth in Section 1066.45.

1) A minimum of 360 minutes of instruction must be provided.

2) Each student must complete the instruction within 30 days after commencement of instruction.

3) The material presented in the course shall be edited for grammar, punctuation and spelling and be of such quality that it does not detract from the subject matter.

4) Advertisement of goods and services shall not appear during instructional time. Material not related to the topic being presented shall not appear during instructional time.

5) To demonstrate that the course contains a minimum of 360 minutes of instruction, the following calculations shall be used:

A) For written material that is read by the student, count the total number of words in the written sections of the course. Divide the word count by 180, the average number of words that a typical student reads per minute. The result equals the time associated with the material for the written sections.

B) For multimedia presentation, including simulators, calculate the total amount of time it takes for all multimedia presentations to play, which shall not exceed 120 minutes.

C) Assign one minute for each chart or graph.

D) If the sum of the time associated with written course material, multimedia presentations, and graphs equals or exceeds 360 minutes, the course has met the minimum content time.

b) In lieu of the time calculation method set forth in subsection (a)(5) a provider may submit alternate methodology to demonstrate that the course contains a minimum of 360 minutes of instruction.

c) All material appearing on screen to be read by the student shall also be spoken aloud to the student, unless this function is manually disabled by the student.

d) Providers must monitor the Illinois General Assembly and update their course content to include any new laws regarding the rules of the road or operation of motor vehicles. This update shall be submitted to the Department for review and approval within 60 days after the effective date of the law change.

e) Criteria for passing the course, in accordance with Section 1066.70, shall be provided to the student prior to the commencement of the course.

f) The course must be designed and well suited for students with minimal keyboarding and/or computer skills.

g) Prior to certification, each applicant shall provide the Department with all necessary information to allow the Department to participate in a complete online adult driver education course, without fee to the Department, so that the Department may determine if the course satisfies the requirements of this Part. If

the proposed course content meets the requirements of this Part, it will be approved by the Department.

h) Providers must follow the classroom course content submitted to and approved by the Department at the time of application for certification. To determine compliance with this provision, the provider shall provide the Department with all necessary information to allow the Department to participate in a complete online adult driver education course, without fee to the Department.

i) If a provider wishes to substantially change the course content, a copy of the proposed revisions must be sent to the Department for approval. The provider shall also provide the Department with all necessary information to allow the Department to participate in a complete adult driver education course, with the proposed revisions included in the course. After review, the Department will send a letter to the provider either approving or rejecting the proposed changes.

j) Within 2 business days after successful completion of an adult driver education course, providers shall electronically transmit to the Secretary the student's full name (first, middle and last), address, date of birth, gender and email address, accompanied by the statutory fee of $5.

Section 1066.45 Online Only Adult Driver Education Course Content

a) Course Objectives. The educational objectives of adult driver education shall include, but not be limited to, promoting respect for and encouraging observance of traffic laws and traffic safety responsibilities of drivers and citizens, reducing traffic violations, reducing traffic-related injuries, deaths and economic losses, and motivating continuing development of traffic related competencies through education, including, but not limited to, Illinois traffic law, risk management, driver attitudes and courtesy skills, and informing participants about the effects of alcohol and other drugs on driving ability.

b) Course Content
At a minimum, course content must include:

1) Familiarization with the process of obtaining an instruction permit and driver's license and the obligations and responsibilities that exist with holding a license;

2) Instruction on traffic laws;

3) Highway signs;

4) Signals and markings that regulate, warn or direct traffic, including traffic signs and lane markings;

5) Issues commonly associated with motor vehicle accidents, including poor decision making, risk taking, distractions, speed, failure to use a safety belt, driving at night, failure to yield the right-of-way, texting while driving and using wireless communication devices;

6) How to respond to emergency vehicles;

7) Turning, passing and yielding;

8) Construction and school zones;

9) Stopping distance;

10) Blind spots;

11) Strategy for driving using:

A) Smith System;

B) IPDE Process;

C) Zone Control;

D) Any other recognized process for identifying problems, predicting outcomes, deciding action and executing decisions;

12) Right-of-way for pedestrians, emergency vehicles and school buses;

13) Sharing the road with pedestrians, bicyclists, motorcyclists, trucks and recreational vehicles;

14) Road hazards, including visibility, weather and traction;

15) Mental conditions, including alertness, awareness and emotion;

16) Alcohol and other drugs, including effects, responsibilities, driving under the influence, zero tolerance, and implied consent laws;

17) Differences in urban and rural driving, including driving on highways and Interstate driving;

18) Organ donor; and

19) Illinois Secretary of State emergency contact database.

c) Providers shall group course content into modules or sections to allow for quizzes in accordance with Section 1066.70.

Section 1066.50 Online Only Adult Driver Education Course Student Instruction Record

a) A provider shall provide for the creation and maintenance of the records documenting student enrollment, the verification of the student's identity, and testing of the student's mastery of the course material. The provider shall also ensure that the student record is readily, securely, and reliably available for inspection by a representative of the Secretary of State. The records shall be maintained for a minimum of 3 years. The student records shall contain the following information:

1) the student's first, middle and last name;

2) the student's residence and email addresses;

3) the student's date of birth and gender;

4) a record of all questions asked and the student's responses;

5) a record of the date and time the student spent in each section and the total instructional time the student spent in the course; and

6) a record of all verification of the student's identity (i.e., if voice biometrics are used, a copy of each voice recording must be maintained).

b) Failure to maintain the required student instruction records, and/or the maintenance of incomplete records, shall be prima facie evidence that the required instruction was not administered.

Section 1066.60 Online Only Adult Driver Education Course Student Contracts

a) Each student shall be informed, prior to the time instruction begins and the collection of any fees, of the amount of any and all fees or charges relative to the adult driver education course, including but not limited to enrollment, tuition, equipment, textbooks and instructional manuals. The provider shall not require mandatory installation or purchase of the provider's proprietary software or shareware, unless this fee was expressly included in the disclosure of fees made prior to enrollment in the course.

b) All contracts or agreements between any provider and any individual or group for the sale, purchase, barter or exchange of any driver education instruction, must contain the following:

1) A statement that the agreement constitutes the entire contract between the provider and the student and that no verbal assurances or promises not contained in the agreement shall bind the provider or the student.

2) A statement indicating that all disputes under this Section shall be directed to the Secretary of State.

c) The term "no refund" and a no refund policy concerning student payments are not permitted in any online adult driver education course contract. A provider may use the phrase: "The provider will not refund any fees if the provider is capable and willing to perform its part of the contract."

d) No provider may sell, transfer, assign, exchange, trade or otherwise dispose of any contract or part of a contract, agreement or obligation between any provider and any student, unless the provider has obtained the written consent of the student.

e) If a provider fails to comply with the provisions of a contract or agreement by or between the provider and any of its students, the provider shall refund all monies paid by the student as consideration for performance of the contract or agreement

by the provider, unless the student violates the provisions of the contract or agreement.

Section 1066.70 Online Only Adult Driver Education Course Provider Verification of Student Identity and Course Completion

a) Prior to certification, providers must submit procedures for verifying the identity of the student taking the course to the Secretary of State, which may include, but are not limited to, the following:

1) Keystroke analysis or unique typing style;

2) Voice recognition;

3) Fingerprint comparison;

4) Web Video Recording;

5) Challenge questions based on third party data (i.e., information obtained from credit bureaus or information brokers). Sample challenge questions must be submitted to the Department as part of provider certification;

6) Web video conference proctor with screen monitoring with live certified proctors.

b) If the method of verification is keystroke analysis or unique typing style, in addition to the initial keystroke analysis, additional analyses must be conducted at least once per hour during the course. Students shall have 60 seconds to provide a keystroke sample. Students who fail to provide a sample or to do so within this specified time period shall be deemed to have failed the course. If the sample does not match the sample provided by the student at the start of the course, the student shall be prevented from completing the course and shall be deemed to have failed the course.

c) If the method of verification is voice recognition, in addition to the initial voice exemplar, the student shall be required to call at least one time per hour, during each hour of the course, during random intervals. Students shall have only 60 seconds to provide a voice exemplar. Students who fail to provide an exemplar or to do so within this specified time period shall be deemed to have failed the

course. If the voice exemplar does not match the exemplar provided by the student at the start of the course, the student shall be prevented from completing the course and shall be deemed to have failed the course.

d) If the method of verification is challenge questions, the student must be asked a minimum of two questions per hour, during each hour of the course, during random intervals. Students shall have only 60 seconds to respond. Students who fail to respond to the question or who fail to respond within the specified time period shall be deemed to have failed the course. A student may answer a maximum of two challenge questions incorrectly. If a student answers a question incorrectly, another challenge question shall be asked. If the student correctly answers the challenge question, the student may proceed with the course. If the student incorrectly answers the second challenge question, the student is deemed to have failed the course.

e) Providers shall incorporate a course content validation process that verifies student participation and comprehension of course material, and course completion, including the following:

1) Built-in timers to ensure that 360 minutes of instruction have been viewed and completed by the student. Timers must prevent the student from scrolling, skipping or advancing through the course without reading the material and must not allow the student to take section quizzes or the final examination without viewing or reading the course content. If a student attempts to take a quiz or the final examination without having spent the minimum time required for a section or the course, the student must be returned to the place in the course where the student last spent the minimum required time.

2) At least one course validation question shall be asked following each multimedia clip that exceeds 60 seconds.

A) For each multimedia presentation that exceeds 60 seconds, at least 4 questions shall be included in the test bank.

B) Questions may be multiple choice, true/false, or a combination of both. Questions shall be difficult enough that the answer may not be easily determined without having viewed the multimedia clip.

C) If the student answers the question incorrectly, the correct answer must be provided to the student, after which the student must view the multimedia clip again. A different question from the test bank shall then be asked. A question may not be repeated until all questions from the test bank have been used.

3) Providers shall test the student's course participation by asking a minimum of 3 questions at the end of each section or module of the course.

A) The test bank for course participation questions shall include a minimum of 5 questions from each section or module.

B) Students must complete a final examination at the end of the course, which shall consist of 20 questions from a test bank of 40 questions.

C) Course participation questions and final examination questions shall be of such difficulty that the answer may not be easily determined without having participated in the course of instruction.

4) A student must score at least 75% on the final examination. If a student scores less than 75%, the student shall be re-tested, using different questions from the test bank. The student is not required to repeat the course, but may be allowed to review the course prior to retaking the examination. If the student fails the comprehensive final examination 2 times, the student has failed the course.

Section 1066.80 Hearings

a) Prior to the denial of a certification of an applicant or existing provider, the Department shall send written notice to the provider. If a formal hearing is requested in writing in accordance with 92 Ill. Adm. Code 1001.Subpart A and IVC Section 2-118, the denial shall stand pending the outcome of the hearing. The denial of a certification shall contain the specific reasons why the certification has been denied.

b) Prior to the suspension or revocation of a provider's certification, the Department will conduct a hearing in accordance with 92 Ill. Adm. Code 1001.Subpart A and IVC Section 2-118, in which the Department will present competent evidence to

establish violations of any regulations or laws governing providers and seek the appropriate sanctions in accordance with Section 1066.90.

Section 1066.90 Denial, Cancellation, Suspension and Revocation of an Online Only Adult Driver Education Course Provider Certification

The Secretary of State may deny, cancel, suspend or revoke a certification:

a) For any violation of IVC Section 6-107.5

b) For any violation of this Part.

c) If the provider's certification or licensure to provide any type of driver education has been denied, cancelled, suspended or revoked.

Section 1066.100 Online Only Adult Driver Education Course Website and Security Requirements

a) Each provider's website must display the following information on its homepage:

1) the provider's Secretary of State certification number;

2) a statement that complaints regarding the provider may be directed to the Secretary of State's Commercial Driver Training School Section. Contact information for the Commercial Driver Training School Section shall be included with the statement.

b) Each provider must offer the course from a single domain. The course may accept students that are redirected to the online course domain, as long as the provider's certification number appears on the source that redirects the student to the online course domain. The student must be redirected to a webpage that clearly identifies the certified provider offering the course before the student begins the registration process, supplies any information, or pays for the course.

c) Providers are prohibited from selling or disclosing any consumer information provided by the student. A statement to that effect must be posted on the provider's website in a conspicuous location.

d) Providers are prohibited from requesting the social security numbers of students.

e) Providers must take all necessary measures to prevent unauthorized access to consumer information, either in printed or electronic form, and, upon discovery, shall immediately report any unauthorized access to the Department.

f) Provider servers must be located in a secure location, with access restricted to only those employees or persons who have a need to access the server.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Pay Plan

2) Code Citation: 80 Ill. Adm. Code 310

3)

Section Numbers:	Adopted Action:
310.47	Amend
310.80	Amend
310.220	Amend
310.410	Amend
310.415	Amend
310.490	Amend
310.495	Amend
310.500	Amend
310.Appendix A Table E	Amend
310.Appendix A Table F	Amend
310.Appendix A Table G	Amend
310.Appendix A Table Q	Amend

4) Statutory Authority: Authorized by Sections 8, 8a and 9(7) of the Personnel Code [20 ILCS 415/8, 20 ILCS 415/8a and 20 ILCS 415/9(7)]

5) Effective Date of Rule: February 4, 2014

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

7) Does this rulemaking contain incorporation by reference? No

8) A statement that 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. Copies of all Pay Plan amendments and collective bargaining contracts are available upon request from the Division of Technical Services and Agency Training and Development.

9) Notices of Proposed published in the *Illinois Register*: 37 Ill. Reg. 16048; October 18, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

11) Differences between Proposal and Final Version: Since the First Notice, the changes are based on two intervening rulemakings and changes provided by JCAR staff in the delta version:

In the table of contents, designations for which sections were part of emergency amendments are removed and the headings for 310.Appendix A Tables A and AD are updated.

The main source notes include a space in a single reference effective July 30, 2010 and references to the two intervening rulemakings.

All section source notes are updated because the amendments will not be adopted until the next calendar year.

In 310.47, technical changes are made.

In 310.410, a space is removed from two titles.

In 310.490, the style of apostrophes is updated, numbers are not written out, and gender-specific language is updated.

In 310.495, the style of quotation marks is updated, unnecessary spaces are removed and a subsection is removed based on intervening rulemaking.

In 310.500, the style of apostrophes and quotation marks is updated.

In 310.Appendix A Tables E and F, the font and placement of rate table effective dates are updated, the former presentation of rate tables are removed, and the Note language is updated by intervening rulemaking and to be more standard.

In 310.Appendix A Table G, minor changes are made to the headings before the rate tables and the Note.

In 310.Appendix A Table Q, the Note has changes in style of apostrophes and presentation of numbers.

Since the First Notice Changes, the Second Notice Changes are:

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

In Section 310.47 (d), the parentheses are removed per JCAR staff recommendation. In subsection (f)(1)(B), the explanation of the asterisk for Storekeeper I and II titles is added.

In Section 310.Appendix A Table E, the Note is altered for clarification.

In Section 310.Appendix A Table F, the rate table heading is corrected and the Note is altered for clarification.

In Section 310.Appendix A Table G, the Note is altered for clarification.

Since the Second Notice Changes, intervening peremptory amendments are added to the Main Source Notes.

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 rule currently in effect? No

14) Are there any rulemakings pending on this Part? Yes

Section Numbers	Proposed Action	*Illinois Register* Citation
310.47	Amendment	38 Ill. Reg. 196, January 3, 2014
310.100	Amendment	38 Ill. Reg. 196, January 3, 2014
310.410	Amendment	38 Ill. Reg. 196, January 3, 2014
310.460	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE B	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE C	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE D	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE E	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE F	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE G	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE H	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE I	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE J	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE K	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE N	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE O	Amendment	38 Ill. Reg. 196, January 3, 2014

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

310.APPENDIX A TABLE P	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE Q	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE R	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE S	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE V	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE W	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE X	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE Y	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE Z	Amendment	38 Ill. Reg. 196, January 3, 2014
310.APPENDIX A TABLE AA	Amendment	38 Ill. Reg. 196, January 3, 2014

15) Summary and Purpose of Rulemaking: In Section 310.47, in-hire rates are lowered to Step 1 for the titles Meat and Poultry Inspector Trainee, Correctional Officer, Correctional Officer Trainee and Forensic Scientist Trainee. In-hire rates are eliminated for the titles Accounting and Fiscal Administration Trainee, Actuarial Examiner Trainee, Civil Engineer I, Financial Institutions Examiner Trainee, Insurance Company Financial Examiner Trainee, Revenue Special Agent Trainee, Terrorism Research Specialist Trainee, Clinical Psychology Associate, Revenue Auditor Trainee and Security Therapy Aid Trainee. To subsection (1) (B), the in-hire rates for the HR-001, RC-019, RC-020 and RC-045 are referenced and/or rearranged.

In Section 310.80 subsection (a) (1), (2) and (3), references to suspending satisfactory performance increases are removed.

In Section 310.220 and subsection (b), the merit compensation system out-of-state rates reference is removed. In subsection (e), the frozen rate reference is removed.

In Section 310.410, the abolished title Fire Certification Specialist is removed and the new titles Fire Certification Specialist I, Fire Certification Specialist II and Fire Certification Specialist Supervisor and their assigned MS-salary ranges are added. The titles were abolished or established effective July 1, 2013 as approved by the Civil Service Commission.

In Sections 310.415(b), 490 (b) (1) and 495 (b) (1), the phrase "in-hiring" is changed to "in-hire." Also in Section 310.490, subsection (g) out-of-state assignment is removed and the remaining subsections renumbered.

In Section 310.500, the definition of "in-hire rate" is added.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

In Section 310.Appendix A Table E, the rate tables are reformatted and include all the titles' new hire rates needed for newly hired employees and promotions. The Note was corrected.

In Section 310.Appendix A Table F, the rate tables are reformatted.

In Section 310.Appendix A Table G, the rate tables are reformatted.

Section 310.Appendix A Table Q reflects the Agreement by and between the Illinois Federation of Public Employees Local 4408, AFT/AFL-CIO and the Department of Central Management Services State of Illinois for RC-033 July 1, 2012 through June 30, 2015 signed July 8, 2013. Steps 1a, 1b and 1c shall be implemented for all employees hired on or after May 1, 2013 with a 3% step differential. Effective July 1, 2013 and 2014, the monthly pay rates shall be increased by 2% for each classification. Effective July 1, 2013, the Step 8 rate shall be increased by $75 per month for those employees who attain ten years of continuous service and have three or more years of creditable service on Step 8 of the same pay grade. For those employees who attain fifteen years of continuous service and have three or more years of creditable service on the same pay grade, the Step 8 rate shall be increased by $100 per month.

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

Mr. Jason Doggett, Manager
Compensation Section
Division of Technical Services and Agency Training and Development
Bureau of Personnel
Department of Central Management Services
504 William G. Stratton Building
Springfield IL 62706

217/782-7964
fax: 217/524-4570
email: CMS.PayPlan@Illinois.gov

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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND POSITION CLASSIFICATIONS
CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

SUBPART A: NARRATIVE

Section
310.20 Policy and Responsibilities
310.30 Jurisdiction
310.40 Pay Schedules
310.45 Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.47 In-Hire Rate
310.50 Definitions
310.60 Conversion of Base Salary to Pay Period Units
310.70 Conversion of Base Salary to Daily or Hourly Equivalents
310.80 Increases in Pay
310.90 Decreases in Pay
310.100 Other Pay Provisions
310.110 Implementation of Pay Plan Changes (Repealed)
310.120 Interpretation and Application of Pay Plan
310.130 Effective Date
310.140 Reinstitution of Within Grade Salary Increases (Repealed)
310.150 Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, effective July 1, 1984 (Repealed)

SUBPART B: SCHEDULE OF RATES

Section
310.205 Introduction
310.210 Prevailing Rate
310.220 Negotiated Rate
310.230 Part-Time Daily or Hourly Special Services Rate (Repealed)
310.240 Daily or Hourly Rate Conversion
310.250 Member, Patient and Inmate Rate

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

310.260 Trainee Rate
310.270 Legislated Rate
310.280 Designated Rate
310.290 Out-of-State Rate (Repealed)
310.295 Foreign Service Rate (Repealed)
310.300 Educator Schedule for RC-063 and HR-010
310.310 Physician Specialist Rate
310.320 Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections (Repealed)
310.330 Excluded Classes Rate (Repealed)

SUBPART C: MERIT COMPENSATION SYSTEM

Section
310.410 Jurisdiction
310.415 Merit Compensation Salary Range Assignments
310.420 Objectives
310.430 Responsibilities
310.440 Merit Compensation Salary Schedule
310.450 Procedures for Determining Annual Merit Increases and Bonuses
310.455 Intermittent Merit Increase (Repealed)
310.456 Merit Zone (Repealed)
310.460 Other Pay Increases
310.470 Adjustment
310.480 Decreases in Pay
310.490 Other Pay Provisions
310.495 Broad-Band Pay Range Classes
310.500 Definitions
310.510 Conversion of Base Salary to Pay Period Units (Repealed)
310.520 Conversion of Base Salary to Daily or Hourly Equivalents
310.530 Implementation
310.540 Annual Merit Increase and Bonus Guidechart
310.550 Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

SUBPART D: FROZEN NEGOTIATED-RATES-OF-PAY DUE TO FISCAL YEAR APPROPRIATIONS AND EXPIRED SALARY SCHEDULES IN COLLECTIVE BARGAINING UNIT AGREEMENTS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section
310.600 Jurisdiction
310.610 Pay Schedules
310.620 In-Hiring Rate
310.630 Definitions
310.640 Increases in Pay
310.650 Other Pay Provisions
310.660 Effective Date
310.670 Negotiated Rate
310.680 Trainee Rate
310.690 Educator Schedule for Frozen RC-063 and Frozen HR-010

310.APPENDIX A Negotiated Rates of Pay
310.TABLE A RC-104 (Conservation Police Supervisors, Laborers' – Illinois Fraternal Order of Police Labor Council)
310.TABLE B VR-706 (Assistant Automotive Shop Supervisors, Automotive Shop Supervisors and Meat and Poultry Inspector Supervisors, Laborers' – ISEA Local #2002)
310.TABLE C RC-056 (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)
310.TABLE D HR-001 (Teamsters Local #700)
310.TABLE E RC-020 (Teamsters Local #330)
310.TABLE F RC-019 (Teamsters Local #25)
310.TABLE G RC-045 (Automotive Mechanics, IFPE)
310.TABLE H RC-006 (Corrections Employees, AFSCME)
310.TABLE I RC-009 (Institutional Employees, AFSCME)
310.TABLE J RC-014 (Clerical Employees, AFSCME)
310.TABLE K RC-023 (Registered Nurses, INA)
310.TABLE L RC-008 (Boilermakers)
310.TABLE M RC-110 (Conservation Police Lodge)
310.TABLE N RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O RC-028 (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE Q RC-033 (Meat Inspectors, IFPE)
310.TABLE R RC-042 (Residual Maintenance Workers, AFSCME)

310.TABLE S VR-704 (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE T HR-010 (Teachers of Deaf, IFT)
310.TABLE U HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V CU-500 (Corrections Meet and Confer Employees)
310.TABLE W RC-062 (Technical Employees, AFSCME)
310.TABLE X RC-063 (Professional Employees, AFSCME)
310.TABLE Y RC-063 (Educators and Educator Trainees, AFSCME)
310.TABLE Z RC-063 (Physicians, AFSCME)
310.TABLE AA NR-916 (Departments of Central Management Services, Natural Resources and Transportation, Teamsters)
310.TABLE AB RC-150 (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AC RC-036 (Public Service Administrators Option 8L Department of Healthcare and Family Services, INA)
310.TABLE AD RC-184 (Blasting Experts, Blasting Specialists and Blasting Supervisors Department of Natural Resources, SEIU Local 73)
310.TABLE AE RC-090 (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294)

310.APPENDIX B Frozen Negotiated-Rates-of-Pay

310.TABLE A Frozen RC-104-Rates-of-Pay (Conservation Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE C Frozen RC-056-Rates-of-Pay (Site Superintendents and Departments of Veterans' Affairs, Natural Resources, Human Services and Agriculture and Historic Preservation Agency Managers, IFPE)
310.TABLE H Frozen RC-006-Rates-of-Pay (Corrections Employees, AFSCME)
310.TABLE I Frozen RC-009-Rates-of-Pay (Institutional Employees, AFSCME)
310.TABLE J Frozen RC-014-Rates-of-Pay (Clerical Employees, AFSCME)
310.TABLE K Frozen RC-023-Rates-of-Pay (Registered Nurses, INA)
310.TABLE M Frozen RC-110-Rates-of-Pay (Conservation Police Lodge)
310.TABLE N Frozen RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O Frozen RC-028-Rates-of-Pay (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P Frozen RC-029-Rates-of-Pay (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE R Frozen RC-042-Rates-of-Pay (Residual Maintenance Workers,

AFSCME)
310.TABLE S Frozen VR-704-Rates-of-Pay (Departments of Corrections, Financial and Professional Regulation, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE T Frozen HR-010-Rates-of-Pay (Teachers of Deaf, IFT)
310.TABLE V Frozen CU-500-Rates-of-Pay (Corrections Meet and Confer Employees)
310.TABLE W Frozen RC-062-Rates-of-Pay (Technical Employees, AFSCME)
310.TABLE X Frozen RC-063-Rates-of-Pay (Professional Employees, AFSCME)
310.TABLE Y Frozen RC-063-Rates-of-Pay (Educators and Educator Trainees, AFSCME)
310.TABLE Z Frozen RC-063-Rates-of-Pay (Physicians, AFSCME)
310.TABLE AB Frozen RC-150-Rates-of-Pay (Public Service Administrators Option 6, AFSCME) (Repealed)
310.TABLE AD Frozen RC-184-Rates-of-Pay (Public Service Administrators Option 8X Department of Natural Resources, SEIU Local 73)
310.TABLE AE Frozen RC-090-Rates-of-Pay (Internal Security Investigators, Metropolitan Alliance of Police Chapter 294)
310.APPENDIX C Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.ILLUSTRATION A Classification Comparison Flow Chart: Both Classes are Whole
310.ILLUSTRATION B Classification Comparison Flow Chart: One Class is Whole and One is Divided
310.ILLUSTRATION C Classification Comparison Flow Chart: Both Classes are Divided
310.APPENDIX D Merit Compensation System Salary Schedule
310.APPENDIX E Teaching Salary Schedule (Repealed)
310.APPENDIX F Physician and Physician Specialist Salary Schedule (Repealed)
310.APPENDIX G Broad-Band Pay Range Classes Salary Schedule

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16,

1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 15043, effective September 24, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 3230, effective January 24, 1986; peremptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; peremptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; peremptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; peremptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; peremptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; peremptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; peremptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; peremptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; peremptory amendment at 11 Ill. Reg. 17919, effective October 19, 1987; peremptory amendment at 11 Ill. Reg. 19812, effective November 19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; peremptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; peremptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; peremptory

amendment at 12 Ill. Reg. 8135, effective April 22, 1988; peremptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; peremptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; peremptory amendment at 13 Ill. Reg. 8080, effective May 10, 1989; amended at 13 Ill. Reg. 8849, effective May 30, 1989; peremptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; peremptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; peremptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; peremptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired February 8, 1991; corrected at 14 Ill. Reg. 16092; peremptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; peremptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; peremptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14, 1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; peremptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; peremptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective February 20, 1992; peremptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; peremptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4,

1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992; peremptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; peremptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; peremptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 31, 1994; peremptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; peremptory amendment at 19 Ill. Reg. 2481, effective February 17, 1995; peremptory amendment at 19 Ill. Reg. 3073, effective February 17, 1995; amended at 19 Ill. Reg. 3456, effective March 7, 1995; peremptory amendment at 19 Ill. Reg. 5145, effective March 14, 1995; amended at 19 Ill. Reg. 6452, effective May 2, 1995; peremptory amendment at 19 Ill. Reg. 6688, effective May 1, 1995; amended at 19 Ill. Reg. 7841, effective June 1, 1995; amended at 19 Ill. Reg. 8156, effective June 12, 1995; amended at 19 Ill. Reg. 9096, effective June 27, 1995; emergency amendment at 19 Ill. Reg. 11954, effective August 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13979, effective September 19, 1995; peremptory amendment at 19 Ill. Reg. 15103, effective October 12, 1995; amended at 19 Ill. Reg. 16160, effective November 28, 1995; amended at 20 Ill. Reg. 308, effective December 22, 1995; emergency amendment at 20 Ill. Reg. 4060, effective February 27, 1996, for a maximum of 150 days; peremptory amendment at 20 Ill. Reg. 6334, effective April 22, 1996; peremptory amendment at 20 Ill. Reg. 7434, effective May 14, 1996; amended at 20 Ill. Reg. 8301, effective June 11, 1996; amended at 20 Ill. Reg. 8657, effective June 20, 1996; amended at 20 Ill. Reg. 9006, effective June 26, 1996; amended at 20 Ill. Reg. 9925, effective July 10, 1996; emergency amendment at 20 Ill. Reg. 10213, effective July 15, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 10841, effective August 5, 1996; peremptory amendment at 20 Ill. Reg. 13408, effective September 24, 1996; amended at 20 Ill. Reg. 15018, effective November 7, 1996; peremptory amendment at 20 Ill. Reg. 15092, effective November 7, 1996; emergency amendment at 21 Ill. Reg. 1023, effective January 6, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 1629, effective

January 22, 1997; amended at 21 Ill. Reg. 5144, effective April 15, 1997; amended at 21 Ill. Reg. 6444, effective May 15, 1997; amended at 21 Ill. Reg. 7118, effective June 3, 1997; emergency amendment at 21 Ill. Reg. 10061, effective July 21, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 12859, effective September 8, 1997, for a maximum of 150 days; peremptory amendment at 21 Ill. Reg. 14267, effective October 14, 1997; peremptory amendment at 21 Ill. Reg. 14589, effective October 15, 1997; peremptory amendment at 21 Ill. Reg. 15030, effective November 10, 1997; amended at 21 Ill. Reg. 16344, effective December 9, 1997; peremptory amendment at 21 Ill. Reg. 16465, effective December 4, 1997; peremptory amendment at 21 Ill. Reg. 17167, effective December 9, 1997; peremptory amendment at 22 Ill. Reg. 1593, effective December 22, 1997; amended at 22 Ill. Reg. 2580, effective January 14, 1998; peremptory amendment at 22 Ill. Reg. 4326, effective February 13, 1998; peremptory amendment at 22 Ill. Reg. 5108, effective February 26, 1998; peremptory amendment at 22 Ill. Reg. 5749, effective March 3, 1998; amended at 22 Ill. Reg. 6204, effective March 12, 1998; peremptory amendment at 22 Ill. Reg. 7053, effective April 1, 1998; peremptory amendment at 22 Ill. Reg. 7320, effective April 10, 1998; peremptory amendment at 22 Ill. Reg. 7692, effective April 20, 1998; emergency amendment at 22 Ill. Reg. 12607, effective July 2, 1998, for a maximum of 150 days; peremptory amendment at 22 Ill. Reg. 15489, effective August 7, 1998; amended at 22 Ill. Reg. 16158, effective August 31, 1998; peremptory amendment at 22 Ill. Reg. 19105, effective September 30, 1998; peremptory amendment at 22 Ill. Reg. 19943, effective October 27, 1998; peremptory amendment at 22 Ill. Reg. 20406, effective November 5, 1998; amended at 22 Ill. Reg. 20581, effective November 16, 1998; amended at 23 Ill. Reg. 664, effective January 1, 1999; peremptory amendment at 23 Ill. Reg. 730, effective December 29, 1998; emergency amendment at 23 Ill. Reg. 6533, effective May 10, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 7065, effective June 3, 1999; emergency amendment at 23 Ill. Reg. 8169, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 11020, effective August 26, 1999; amended at 23 Ill. Reg. 12429, effective September 21, 1999; peremptory amendment at 23 Ill. Reg. 12493, effective September 23, 1999; amended at 23 Ill. Reg. 12604, effective September 24, 1999; amended at 23 Ill. Reg. 13053, effective September 27, 1999; peremptory amendment at 23 Ill. Reg. 13132, effective October 1, 1999; amended at 23 Ill. Reg. 13570, effective October 26, 1999; amended at 23 Ill. Reg. 14020, effective November 15, 1999; amended at 24 Ill. Reg. 1025, effective January 7, 2000; peremptory amendment at 24 Ill. Reg. 3399, effective February 3, 2000; amended at 24 Ill. Reg. 3537, effective February 18, 2000; amended at 24 Ill. Reg. 6874, effective April 21, 2000; amended at 24 Ill. Reg. 7956, effective May 23, 2000; emergency amendment at 24 Ill. Reg. 10328, effective July 1, 2000, for a maximum of 150 days; emergency expired November 27, 2000; peremptory amendment at 24 Ill. Reg. 10767, effective July 3, 2000; amended at 24 Ill. Reg. 13384, effective August 17, 2000; peremptory amendment at 24 Ill. Reg. 14460, effective September 14, 2000; peremptory amendment at 24 Ill. Reg. 16700, effective October 30, 2000; peremptory

amendment at 24 Ill. Reg. 17600, effective November 16, 2000; amended at 24 Ill. Reg. 18058, effective December 4, 2000; peremptory amendment at 24 Ill. Reg. 18444, effective December 1, 2000; amended at 25 Ill. Reg. 811, effective January 4, 2001; amended at 25 Ill. Reg. 2389, effective January 22, 2001; amended at 25 Ill. Reg. 4552, effective March 14, 2001; peremptory amendment at 25 Ill. Reg. 5067, effective March 21, 2001; amended at 25 Ill. Reg. 5618, effective April 4, 2001; amended at 25 Ill. Reg. 6655, effective May 11, 2001; amended at 25 Ill. Reg. 7151, effective May 25, 2001; peremptory amendment at 25 Ill. Reg. 8009, effective June 14, 2001; emergency amendment at 25 Ill. Reg. 9336, effective July 3, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 9846, effective July 23, 2001; amended at 25 Ill. Reg. 12087, effective September 6, 2001; amended at 25 Ill. Reg. 15560, effective November 20, 2001; peremptory amendment at 25 Ill. Reg. 15671, effective November 15, 2001; amended at 25 Ill. Reg. 15974, effective November 28, 2001; emergency amendment at 26 Ill. Reg. 223, effective December 21, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 1143, effective January 17, 2002; amended at 26 Ill. Reg. 4127, effective March 5, 2002; peremptory amendment at 26 Ill. Reg. 4963, effective March 15, 2002; amended at 26 Ill. Reg. 6235, effective April 16, 2002; emergency amendment at 26 Ill. Reg. 7314, effective April 29, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 10425, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10952, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13934, effective September 10, 2002; amended at 26 Ill. Reg. 14965, effective October 7, 2002; emergency amendment at 26 Ill. Reg. 16583, effective October 24, 2002, for a maximum of 150 days; emergency expired March 22, 2003; peremptory amendment at 26 Ill. Reg. 17280, effective November 18, 2002; amended at 26 Ill. Reg. 17374, effective November 25, 2002; amended at 26 Ill. Reg. 17987, effective December 9, 2002; amended at 27 Ill. Reg. 3261, effective February 11, 2003; expedited correction at 28 Ill. Reg. 6151, effective February 11, 2003; amended at 27 Ill. Reg. 8855, effective May 15, 2003; amended at 27 Ill. Reg. 9114, effective May 27, 2003; emergency amendment at 27 Ill. Reg. 10442, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; peremptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; peremptory amendment at 28 Ill. Reg. 1441, effective January 9, 2004; amended at 28 Ill. Reg. 2684, effective January 22, 2004; amended at 28 Ill. Reg. 6879, effective April 30, 2004; peremptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; peremptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; peremptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; peremptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; peremptory amendment at 28 Ill. Reg. 13656, effective September 27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a maximum of 150 days; emergency expired March 13, 2005; peremptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; peremptory amendment at 28 Ill. Reg. 15336, effective

November 15, 2004; peremptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; peremptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; peremptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; peremptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; peremptory amendment at 29 Ill. Reg. 2050, effective January 19, 2005; peremptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; peremptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; peremptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; peremptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; peremptory amendment at 29 Ill. Reg. 8214, effective May 23, 2005; peremptory amendment at 29 Ill. Reg. 8418, effective June 1, 2005; amended at 29 Ill. Reg. 9319, effective July 1, 2005; peremptory amendment at 29 Ill. Reg. 12076, effective July 15, 2005; peremptory amendment at 29 Ill. Reg. 13265, effective August 11, 2005; amended at 29 Ill. Reg. 13540, effective August 22, 2005; peremptory amendment at 29 Ill. Reg. 14098, effective September 2, 2005; amended at 29 Ill. Reg. 14166, effective September 9, 2005; amended at 29 Ill. Reg. 19551, effective November 21, 2005; emergency amendment at 29 Ill. Reg. 20554, effective December 2, 2005, for a maximum of 150 days; peremptory amendment at 29 Ill. Reg. 20693, effective December 12, 2005; peremptory amendment at 30 Ill. Reg. 623, effective December 28, 2005; peremptory amendment at 30 Ill. Reg. 1382, effective January 13, 2006; amended at 30 Ill. Reg. 2289, effective February 6, 2006; peremptory amendment at 30 Ill. Reg. 4157, effective February 22, 2006; peremptory amendment at 30 Ill. Reg. 5687, effective March 7, 2006; peremptory amendment at 30 Ill. Reg. 6409, effective March 30, 2006; amended at 30 Ill. Reg. 7857, effective April 17, 2006; amended at 30 Ill. Reg. 9438, effective May 15, 2006; peremptory amendment at 30 Ill. Reg. 10153, effective May 18, 2006; peremptory amendment at 30 Ill. Reg. 10508, effective June 1, 2006; amended at 30 Ill. Reg. 11336, effective July 1, 2006; emergency amendment at 30 Ill. Reg. 12340, effective July 1, 2006, for a maximum of 150 days; peremptory amendment at 30 Ill. Reg. 12418, effective July 1, 2006; amended at 30 Ill. Reg. 12761, effective July 17, 2006; peremptory amendment at 30 Ill. Reg. 13547, effective August 1, 2006; peremptory amendment at 30 Ill. Reg. 15059, effective September 5, 2006; peremptory amendment at 30 Ill. Reg. 16439, effective September 27, 2006; emergency amendment at 30 Ill. Reg. 16626, effective October 3, 2006, for a maximum of 150 days; peremptory amendment at 30 Ill. Reg. 17603, effective October 20, 2006; amended at 30 Ill. Reg. 18610, effective November 20, 2006; peremptory amendment at 30 Ill. Reg. 18823, effective November 21, 2006; peremptory amendment at 31 Ill. Reg. 230, effective December 20, 2006; emergency amendment at 31 Ill. Reg. 1483, effective January 1, 2007, for a maximum of 150 days; peremptory amendment at 31 Ill. Reg. 2485, effective January 17, 2007; peremptory amendment at 31 Ill. Reg. 4445, effective February 28, 2007; amended at 31 Ill. Reg. 4982, effective March 15, 2007; peremptory amendment at 31 Ill. Reg. 7338, effective May 3, 2007; amended at 31 Ill. Reg. 8901, effective July 1, 2007;

emergency amendment at 31 Ill. Reg. 10056, effective July 1, 2007, for a maximum of 150 days; peremptory amendment at 31 Ill. Reg. 10496, effective July 6, 2007; peremptory amendment at 31 Ill. Reg. 12335, effective August 9, 2007; emergency amendment at 31 Ill. Reg. 12608, effective August 16, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 13220, effective August 30, 2007, for a maximum of 150 days; peremptory amendment at 31 Ill. Reg. 13357, effective August 29, 2007; amended at 31 Ill. Reg. 13981, effective September 21, 2007; peremptory amendment at 31 Ill. Reg. 14331, effective October 1, 2007; amended at 31 Ill. Reg. 16094, effective November 20, 2007; amended at 31 Ill. Reg. 16792, effective December 13, 2007; peremptory amendment at 32 Ill. Reg. 598, effective December 27, 2007; amended at 32 Ill. Reg. 1082, effective January 11, 2008; peremptory amendment at 32 Ill. Reg. 3095, effective February 13, 2008; peremptory amendment at 32 Ill. Reg. 6097, effective March 25, 2008; peremptory amendment at 32 Ill. Reg. 7154, effective April 17, 2008; expedited correction at 32 Ill. Reg. 9747, effective April 17, 2008; peremptory amendment at 32 Ill. Reg. 9360, effective June 13, 2008; amended at 32 Ill. Reg. 9881, effective July 1, 2008; peremptory amendment at 32 Ill. Reg. 12065, effective July 9, 2008; peremptory amendment at 32 Ill. Reg. 13861, effective August 8, 2008; peremptory amendment at 32 Ill. Reg. 16591, effective September 24, 2008; peremptory amendment at 32 Ill. Reg. 16872, effective October 3, 2008; peremptory amendment at 32 Ill. Reg. 18324, effective November 14, 2008; peremptory amendment at 33 Ill. Reg. 98, effective December 19, 2008; amended at 33 Ill. Reg. 2148, effective January 26, 2009; peremptory amendment at 33 Ill. Reg. 3530, effective February 6, 2009; peremptory amendment at 33 Ill. Reg. 4202, effective February 26, 2009; peremptory amendment at 33 Ill. Reg. 5501, effective March 25, 2009; peremptory amendment at 33 Ill. Reg. 6354, effective April 15, 2009; peremptory amendment at 33 Ill. Reg. 6724, effective May 1, 2009; peremptory amendment at 33 Ill. Reg. 9138, effective June 12, 2009; emergency amendment at 33 Ill. Reg. 9432, effective July 1, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 10211, effective July 1, 2009; peremptory amendment at 33 Ill. Reg. 10823, effective July 2, 2009; peremptory amendment at 33 Ill. Reg. 11082, effective July 10, 2009; peremptory amendment at 33 Ill. Reg. 11698, effective July 23, 2009; peremptory amendment at 33 Ill. Reg. 11895, effective July 31, 2009; peremptory amendment at 33 Ill. Reg. 12872, effective September 3, 2009; amended at 33 Ill. Reg. 14944, effective October 26, 2009; peremptory amendment at 33 Ill. Reg. 16598, effective November 13, 2009; peremptory amendment at 34 Ill. Reg. 305, effective December 18, 2009; emergency amendment at 34 Ill. Reg. 957, effective January 1, 2010, for a maximum of 150 days; peremptory amendment at 34 Ill. Reg. 1425, effective January 5, 2010; peremptory amendment at 34 Ill. Reg. 3684, effective March 5, 2010; peremptory amendment at 34 Ill. Reg. 5776, effective April 2, 2010; peremptory amendment at 34 Ill. Reg. 6214, effective April 16, 2010; amended at 34 Ill. Reg. 6583, effective April 30, 2010; peremptory amendment at 34 Ill. Reg. 7528, effective May 14, 2010; amended at 34 Ill. Reg. 7645, effective May 24, 2010; peremptory amendment at 34 Ill. Reg. 7947, effective May

26, 2010; peremptory amendment at 34 Ill. Reg. 8633, effective June 18, 2010; amended at 34 Ill. Reg. 9759, effective July 1, 2010; peremptory amendment at 34 Ill. Reg. 10536, effective July 9, 2010; peremptory amendment at 34 Ill. Reg. 11864, effective July 30, 2010; emergency amendment at 34 Ill. Reg. 12240, effective August 9, 2010, for a maximum of 150 days; peremptory amendment at 34 Ill. Reg. 13204, effective August 26, 2010; peremptory amendment at 34 Ill. Reg. 13657, effective September 8, 2010; peremptory amendment at 34 Ill. Reg. 15897, effective September 30, 2010; peremptory amendment at 34 Ill. Reg. 18912, effective November 15, 2010; peremptory amendment at 34 Ill. Reg. 19582, effective December 3, 2010; amended at 35 Ill. Reg. 765, effective December 30, 2010; emergency amendment at 35 Ill. Reg. 1092, effective January 1, 2011, for a maximum of 150 days; peremptory amendment at 35 Ill. Reg. 2465, effective January 19, 2011; peremptory amendment at 35 Ill. Reg. 3577, effective February 10, 2011; emergency amendment at 35 Ill. Reg. 4412, effective February 23, 2011, for a maximum of 150 days; peremptory amendment at 35 Ill. Reg. 4803, effective March 11, 2011; emergency amendment at 35 Ill. Reg. 5633, effective March 15, 2011, for a maximum of 150 days; peremptory amendment at 35 Ill. Reg. 5677, effective March 18, 2011; amended at 35 Ill. Reg. 8419, effective May 23, 2011; amended at 35 Ill. Reg. 11245, effective June 28, 2011; emergency amendment at 35 Ill. Reg. 11657, effective July 1, 2011, for a maximum of 150 days; emergency expired November 27, 2011; peremptory amendment at 35 Ill. Reg. 12119, effective June 29, 2011; peremptory amendment at 35 Ill. Reg. 13966, effective July 29, 2011; peremptory amendment at 35 Ill. Reg. 15178, effective August 29, 2011; emergency amendment at 35 Ill. Reg. 15605, effective September 16, 2011, for a maximum of 150 days; peremptory amendment at 35 Ill. Reg. 15640, effective September 15, 2011; peremptory amendment at 35 Ill. Reg. 19707, effective November 23, 2011; amended at 35 Ill. Reg. 20144, effective December 6, 2011; amended at 36 Ill. Reg. 153, effective December 22, 2011; peremptory amendment at 36 Ill. Reg. 564, effective December 29, 2011; peremptory amendment at 36 Ill. Reg. 3957, effective February 24, 2012; peremptory amendment at 36 Ill. Reg. 4158, effective March 5, 2012; peremptory amendment at 36 Ill. Reg. 4437, effective March 9, 2012; amended at 36 Ill. Reg. 4707, effective March 19, 2012; amended at 36 Ill. Reg. 8460, effective May 24, 2012; peremptory amendment at 36 Ill. Reg. 10518, effective June 27, 2012; emergency amendment at 36 Ill. Reg. 11222, effective July 1, 2012, for a maximum of 150 days; peremptory amendment at 36 Ill. Reg. 13680, effective August 15, 2012; peremptory amendment at 36 Ill. Reg. 13973, effective August 22, 2012; peremptory amendment at 36 Ill. Reg. 15498, effective October 16, 2012; amended at 36 Ill. Reg. 16213, effective November 1, 2012; peremptory amendment at 36 Ill. Reg. 17138, effective November 20, 2012; peremptory amendment at 37 Ill. Reg. 3408, effective March 7, 2013; amended at 37 Ill. Reg. 4750, effective April 1, 2013; peremptory amendment at 37 Ill. Reg. 5925, effective April 18, 2013; peremptory amendment at 37 Ill. Reg. 9563, effective June 19, 2013; amended at 37 Ill. Reg. 9939, effective July 1, 2013; emergency amendment at 37 Ill. Reg. 11395, effective July 1, 2013, for a maximum of 150 days;

peremptory amendment at 37 Ill. Reg. 11524, effective July 3, 2013; peremptory amendment at 37 Ill. Reg. 12588, effective July 19, 2013; peremptory amendment at 37 Ill. Reg. 13762, effective August 8, 2013; peremptory amendment at 37 Ill. Reg. 14219, effective August 23, 2013; amended at 37 Ill. Reg. 16925, effective October 8, 2013; peremptory amendment at 37 Ill. Reg. 17164, effective October 18, 2013; peremptory amendment at 37 Ill. Reg. 20410, effective December 6, 2013; peremptory amendment at 38 Ill. Reg. 2974, effective January 9, 2014; amended at 38 Ill. Reg. 5250, effective February 4, 2014.

SUBPART A: NARRATIVE

Section 310.47 In-Hire Rate

a) Use – No employee in a position in which the position and/or the employee meet the criteria of an in-hire rate receives less than the in-hire rate. The in-hire rate is used when a candidate only meets the minimum requirements of the class specification upon entry to State service (Section 310.100(b)(1), 310.490(b)(1) or 310.495(b)(1)), when an employee moves to a vacant position (Section 310.45) or when an MS salary range is assigned to a Trainee Program (Section 310.415(b)).

b) Request – An agency head may request in writing that the Director of Central Management Services approve or negotiate an in-hire rate. The in-hire rate is a Step or dollar amount depending on whether the classification title is assigned to a negotiated full scale rate, negotiated pay grade, merit compensation salary range or broad-band salary range. The in-hire rate may be for the classification title or limited within the classification title to the agency, facilities, counties or other criteria. The supporting justifications for the requested in-hire rate and the limitations are included in the agency request. An effective date may be included in the request.

c) Review – The Director of Central Management Services shall review the supporting justifications, the turnover rate, length of vacancies, and the currently filled positions for the classification title, and the market starting rates for similar classes, and consult with other agencies using the classification title. Other factors may be included in the review and negotiation of negotiated in-hire rates.

d) Approval or Negotiated –

1) Approval − The Director of Central Management Services indicates in writing the approved in-hire rate and effective date, which is either the date requested by the agency or the beginning of the next pay period after the approval.

2) Negotiated – The Director of Central Management Services and the bargaining unit representative indicate in writing the in-hire rates~~rate(s)~~ and effective date, which is either the date indicated in the agreement, the date of the agreement's signature or the beginning of the next pay period after the signatures are secured on the agreement.

e) Implementation – In the classification title or within the limitations of the classification title and when the in-hire rate is above the normal minimum of the assigned salary range or pay grade, an employee paid below the in-hire rate receives the in-hire rate on the approved effective date. The in-hire rate remains in effect for any employee entering the title or the limits within the title until the title is abolished or an agency request to rescind the in-hire rate is approved by the Director of Central Management Services or negotiated by the Director of Central Management Services and the bargaining unit representative.

f) Approved or Negotiated In-Hire Rates –

1) Assigned to a Classification –

A) Approved and Assigned to a Pay Grade or Salary Range −

Title	Pay Grade or Salary Range	Effective Date	In-Hire Rate
~~Accounting & Fiscal Administration Career Trainee~~	~~RC-062-12~~	~~January 1, 2008~~	~~Step 3~~
~~Actuarial Examiner Trainee~~	~~RC-062-13~~	~~January 1, 2008~~	~~Step 4~~
~~Civil Engineer I~~	~~RC-063-15~~	~~January 1, 2008~~	~~Step 2~~
Commerce Commission Police Officer Trainee	MS-10	January 1, 2008	$2,943
Correctional Officer	RC-006-09	January 1, 2008	Step 1~~2~~
Correctional Officer Trainee	RC-006-05	January 1, 2008	Step1~~-4~~

Environmental Engineer I	RC-063-15	January 1, 2008	Step 2
Environmental Protection Engineer I	RC-063-15	January 1, 2008	Step 5
Environmental Protection Engineer II	RC-063-17	January 1, 2008	Step 4
~~Financial Institutions Examiner Trainee~~	~~RC-062-13~~	~~January 1, 2008~~	~~Step 2~~
~~Insurance Company Financial Examiner Trainee~~	~~RC-062-13~~	~~January 1, 2008~~	~~Step 4~~
Internal Auditor Trainee	MS-09	January 1, 2008	$2,854
~~Revenue Special Agent Trainee~~	~~RC-062-14~~	~~January 1, 2008~~	~~Step 2~~
~~Terrorism Research Specialist Trainee~~	~~RC-062-14~~	~~January 1, 2008~~	~~Step 2~~

B) Negotiated and Assigned to a Full Scale Rate – The ~~full scale~~ rates are located in ~~Section 310.~~Appendix A Table D for bargaining unit HR-001, in Appendix A Table E for bargaining unit RC-020, in Appendix A Table F for RC-019 and in Appendix A Table G for bargaining unit RC-045.

Title	Bargaining Unit	Effective Date	In-Hire Rate
Auto & Body Repairer	RC-045	July 1, 2013	75%
Automotive Attendant I	RC-045	July 1, 2013	75%
Automotive Attendant II	RC-045	July 1, 2013	75%
Automotive Mechanic	RC-045	July 1, 2013	75%
Automotive Parts Warehouse Specialist	RC-045	July 1, 2013	75%
Automotive Parts Warehouser	RC-045	July 1, 2013	75%
Bridge Mechanic	RC-019	July 8, 2013	75%
Bridge Mechanic	RC-020	June 26, 2013	75%
Bridge Tender	RC-019	July 8, 2013	75%
Bridge Tender	RC-020	June 26, 2013	75%
Building Services Worker	HR-001	July 24, 2013	75%
Deck Hand	RC-019	July 8, 2013	75%
Elevator Operator	HR-001	July 24, 2013	75%
Ferry Operator I	RC-019	July 8, 2013	75%

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Ferry Operator II	RC-019	July 8, 2013	75%
Grounds Supervisor	HR-001	July 24, 2013	75%
Heavy Construction Equipment Operator	HR-001	July 24, 2013	75%
Heavy Construction Equipment Operator	RC-020	June 26, 2013	75%
Highway Maintainer	HR-001	November 1, 2009	75%
Highway Maintainer	RC-019	July 8, 2013	75%
Highway Maintainer	RC-020	June 26, 2013	75%
Highway Maintenance Lead Worker	HR-001	July 24, 2013	75%
Highway Maintenance Lead Worker	RC-019	July 8, 2013	75%
Highway Maintenance Lead Worker	RC-020	June 26, 2013	75%
Highway Maintenance Lead Worker (Lead Lead Worker)	RC-019	July 8, 2013	75%
Highway Maintenance Lead Worker (Lead Lead Worker)	RC-020	June 26, 2013	75%
Janitor I (Including Office of Administration)	RC-019	July 8, 2013	75%
Janitor II (Including Office of Administration)	RC-019	July 8, 2013	75%
Labor Maintenance Lead Worker	RC-019	July 8, 2013	75%
Labor Maintenance Lead Worker	RC-020	June 26, 2013	75%
Laborer (Maintenance)	HR-001	July 24, 2013	75%
Laborer (Maintenance)	RC-019	July 8, 2013	75%
Laborer (Maintenance)	RC-020	June 26, 2013	75%
Maintenance Equipment Operator	HR-001	July 24, 2013	75%
Maintenance Equipment Operator	RC-019	July 8, 2013	75%
Maintenance Equipment Operator	RC-020	June 26, 2013	75%
Maintenance Worker	HR-001	July 24, 2013	75%
Maintenance Worker	RC-019	July 8, 2013	75%

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Maintenance Worker	RC-020	June 26, 2013	75%
Power Shovel Operator (Maintenance)	HR-001	July 24, 2013	75%
Power Shovel Operator (Maintenance)	RC-019	July 8, 2013	75%
Power Shovel Operator (Maintenance)	RC-020	June 26, 2013	75%
Security Guard I	RC-019	July 8, 2013	75%
Security Guard II	RC-019	July 8, 2013	75%
Silk Screen Operator	RC-019	July 8, 2013	75%
Silk Screen Operator	RC-020	June 26, 2013	75%
Small Engine Mechanic	RC-045	July 1, 2013	75%
Storekeeper I*	RC-045	July 1, 2013	75%
Storekeeper II*	RC-045	July 1, 2013	75%

*Storekeeper I and Storekeeper II serving as Automotive Parts Warehouser in Cook County.

~~Title~~	~~Bargaining Unit of the Full Scale Rate~~	~~Effective Date~~	~~In-Hire Rate~~
~~Highway Maintainer~~	~~HR-001~~	~~November 1, 2009~~	~~75%~~
~~Building Services Worker~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Elevator Operator~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Grounds Supervisor~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Heavy Construction Equipment Operator~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Highway Maintenance Lead Worker~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Laborer (Maintenance)~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Maintenance Equipment Operator~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Maintenance Worker~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~
~~Power Shovel Operator (Maintenance)~~	~~HR-001~~	~~July 24, 2013~~	~~75%~~

2) Based on the Position's Work Location or Employee's Credential or Residency –

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Title	Pay Grade or Salary Range	Location or Residency	Credential	Effective Date	In-Hire Rate
Civil Engineer Trainee	NR-916	None identified	Bachelor's degree in accredited civil engineering program	January 1, 2008	Add to minimum monthly rate $40/ quarter work experience up to 8
Civil Engineer Trainee	NR-916	None identified	Passed Engineering Intern exam	January 1, 2008	Add to minimum monthly rate $60/month
Civil Engineer Trainee	NR-916	None identified	Master's degree	January 1, 2009	Add to minimum monthly rate $60/month for each year experience up to two years
~~Clinical Psychology Associate~~	~~RC-063-18~~	~~None identified~~	~~Completed doctoral dissertation~~	~~February 1, 2008~~	~~Step 3~~
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 2 years of college in civil engineering or job related technical/ science curriculum (60 semester	January 1, 2011 January 1, 2012	$2,705 $2,845

			/90 quarter hours credit)		
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 3 years of college in areas other than civil engineering or job related technical/ science curriculum (90 semester /135 quarter hours credit)	January 1, 2011 January 1, 2012	$2,600 $2,730
Engineering Technician I, II, III and IV	NR-916	None identified	Associate Degree from an accredited 2 year civil engineering technology program	January 1, 2011 January 1, 2012	$2,830 $2,975
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 3 years of college courses in civil engineering or job related technical/ science curriculum (90 semester /135 quarter hours credit)	January 1, 2011 January 1, 2012	$2,830 $2,975

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Engineering Technician I, II, III and IV	NR-916	None identified	Completed 4 years of college courses in areas other than civil engineering or job related technical/ science curriculum (120 semester /180 quarter hours credit)	January 1, 2011	$2,705
				January 1, 2012	$2,845
Engineering Technician I, II, III and IV	NR-916	None identified	Completed 4 years of college in civil engineering or job related technical/ science curriculum (120 semester/180 quarter hours credit includes appointees from unaccredited engineering programs and those who have not yet obtained a degree)	January 1, 2011	$2,945
				January 1, 2012	$3,095
	NR-916	None identified	Bachelor of Science	January 1, 2011	$3,340

Engineering Technician I, II, III and IV			Degree from an accredited 4 year program in civil engineering technology, industrial technology, and construction technology	January 1, 2012	$3,510
Forensic Scientist Trainee	RC-062-15	None identified	Meets minimum class require-ments or completed Forensic Science Residency Program at the U of I-Chicago	January 1, 2008	Step 1~~2~~
~~Forensic Scientist Trainee~~	~~RC-062-15~~	~~None identified~~	~~Completed Forensic Science Residency Program at the U of I-Chicago~~	~~January 1, 2008~~	~~Step 3~~
Information Services Intern	RC-063-15	Work outside Cook County	Computer Science degree at 4-year college	January 1, 2008	Step 4
Information Services Intern	RC-063-15	Work in Cook County	Computer Science degree at 4-year college	January 1, 2008	Step 6

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Information Services Intern	RC-063-15	Work outside Cook County	Computer Science degree at 2-year technical school	January 1, 2008	Step 2
Information Services Intern	RC-063-15	Work in Cook County	Computer Science degree at 2-year technical school	January 1, 2008	Step 4
Information Services Intern	RC-063-15	Work in Cook County	Non-Computer Science degree at 4-year college	January 1, 2008	Step 3
Information Services Specialist I	RC-063-17	Work in Cook County	None identified beyond class requirements	January 1, 2008	Step 2
Juvenile Justice Specialist	RC-006-14	None identified	Master's degree	September 1, 2008	Step 2
Juvenile Justice Specialist Intern	RC-006-11	None identified	Master's degree	September 1, 2008	Step 2
Meat & Poultry Inspector Trainee	RC-033	Work in Regions 1 and 6	None identified beyond class requirements	January 1, 2008	Step 1~~3~~
Physician Specialist, Option C	RC-063-MD-C	Work in Singer, McFarland, Choate, Chester, Alton, Murray,	None identified beyond class requirements	January 1, 2008	Step 5

		and Mabley facilities			
Physician Specialist, Option D	RC-063-MD-D	Work in Singer, McFarland, Choate, Chester, Alton, Murray, and Mabley facilities	None identified beyond class requirements	January 1, 2008	Step 5
Products & Standards Inspector Trainee	MS-09	Work in Cook, DuPage, Lake, Kane, and Will counties	None identified beyond class requirements	January 1, 2008	$3,057
Products & Standards Inspector Trainee	MS-09	Work in counties outside Cook, DuPage, Lake, Kane, and Will counties	None identified beyond class requirements	January 1, 2008	$2,854
~~Revenue Auditor Trainee~~	~~RC-062-12~~	~~Work in IL~~	~~None identified beyond class requirements~~	~~January 1, 2008~~	~~Step 5~~
~~Revenue Auditor Trainee~~	~~RC-062-15~~	~~See Note in Appendix A Table W~~	~~None identified beyond class requirements~~	~~January 1, 2008~~	~~Step 5~~
~~Revenue Auditor Trainee~~	~~RC-062-13~~	~~States other than IL and not assigned to RC-062-15~~	~~None identified beyond class requirements~~	~~January 1, 2008~~	~~Step 5~~

~~Security Therapy Aide Trainee~~	~~RC-009-13~~	~~Work in Joliet Treatment and Detention Facility~~	~~None identified beyond class requirements~~	~~January 1, 2008~~	~~Step 5~~
Telecommunicator	RC-014-12	Work in District 2	None identified beyond class requirements	January 1, 2008	Step 2
Telecommunicator Trainee	RC-014-10	Work in Kane County	None identified beyond class requirements	January 1, 2008	Step 3
Telecommunicator Trainee	RC-014-10	Work in Cook County	None identified beyond class requirements	January 1, 2008	Step 7

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

Section 310.80 Increases in Pay

Except as otherwise provided for in this Section, for employees occupying positions in classes that are paid in conformance with the Schedule of Negotiated Rates (Appendix A) and without a negotiated provision in the currently effective bargaining unit agreement, increases shall be granted as follows and will become effective the first day of the pay period following the date of approval:

a) Satisfactory Performance Increase –

1) Each employee who has not attained Step 8 of the relevant pay grade, and whose level of performance has been at a satisfactory level of competence, shall be successively advanced in pay to the next higher step in the pay grade after one year of creditable service in the same class. ~~Effective July 1, 2012, the satisfactory performance increases are suspended. Effective April 17, 2013, employees in positions represented by an American Federation of State, County and Municipal Employees bargaining unit (CU-500, RC-006, RC-009, RC-010, RC-014, RC-028, RC-042, RC-062~~

~~and RC-063) receive satisfactory performance or step increases that they are or would have been eligible for during Fiscal Year 2013 (July 1, 2012 through June 30, 2013).~~

2) A satisfactory performance increase shall become effective on the first day of the month within which the required period of creditable service is reached. ~~Effective July 1, 2012, the satisfactory performance increases are suspended. Effective April 17, 2013, employees in positions represented by an American Federation of State, County and Municipal Employees bargaining unit (CU-500, RC-006, RC-009, RC-010, RC-014, RC-028, RC-042, RC-062 and RC-063) receive satisfactory performance or step increases that they are or would have been eligible for during Fiscal Year 2013 (July 1, 2012 through June 30, 2013).~~

3) No satisfactory performance increase may be given after the effective date of separation. ~~The exception is an employee in a position represented by an American Federation of State, County and Municipal Employees bargaining unit (CU-500, RC-006, RC-009, RC-010, RC-014, RC-028, RC-042, RC-062 and RC-063) who separated during Fiscal Year 2013 between July 1, 2012 and April 17, 2013 and who otherwise would receive a satisfactory performance or step increase based on subsection (a)(1) and (2).~~

b) Withholding Satisfactory Performance Increase – As an inducement toward attainment of satisfactory level of competence, satisfactory performance increases may be withheld from the employee who has not achieved a satisfactory level of performance. Such action must be supported by:

1) A performance record showing less than satisfactory performance. This must be prepared by the appropriate supervisor, discussed with the employee and approved by the agency head prior to the date the increase would otherwise become effective. The performance record will not be invalidated by refusal of an employee to sign. In such cases, an explanatory comment shall be made on the record by the supervisor. This record will be preserved by the agency.

2) Notice of withholding of satisfactory performance increases to the Department of Central Management Services – It shall be reported upon

completion of action required by subsection (b)(1), but not later than the submission of the payroll reflecting the denial of the increase.

c) Redetermination – A satisfactory performance increase previously withheld shall be granted when the cause for withholding has been eliminated. Redetermination must be made at least annually. In such cases the increases will be effective the first day of the month following date of approval and will be preceded by the preparation and filing of a Performance Record within the agency indicating the attainment of satisfactory level of competence.

d) Other Pay Increases –

1) Promotion −

A) Standard Procedures –

i) From Other Than Step 8 – Normally, upon promotion, an employee shall be advanced to the lowest step in the targeted pay grade that represents at least a full step increase in the former pay grade.

ii) From Step 8 – The employee shall be paid at the lowest step rate in the targeted pay grade that results in an increase equal to at least the dollar difference between Step 7 and Step 8 in the former pay grade. To compute this, add the dollar difference between Step 7 and Step 8 in the former pay grade to the employee's current rate at Step 8 (then include longevity if the employee is receiving an increased rate based on longevity). Then place the employee on the lowest step in the targeted pay grade that is at least equivalent to that amount. Otherwise, when an employee is promoted from Step 8, the employee shall be paid at the lowest step rate in the targeted pay grade that results in an increase equal to at least 3%. To compute this, add 3% to the employee's current rate at Step 8 (then include longevity if the employee is receiving an increased rate based on longevity). Then place the employee on the

lowest step in the targeted pay grade that is at least equivalent to that amount.

B) Exception – Any deviation is a special salary adjustment (see subsection (e)).

2) Reallocation –

A) Standard Procedures −

i) From Other Than Step 8 − Normally, upon reallocation, an employee shall be advanced to the lowest step in the targeted pay grade that represents at least a full step increase in the former pay grade.

ii) From Step 8 − When an employee is reallocated from Step 8, the employee shall be paid at the lowest step rate in the targeted pay grade that results in an increase equal to at least 3%. To compute this, add 3% to the employee's current rate at Step 8 (then include longevity if the employee is receiving an increased rate based on longevity). Then place the employee on the lowest step in the targeted pay grade that is at least equivalent to that amount. The reallocation shall not change the creditable service date for non-bargaining-unit employees or if the increase is less than one step for the bargaining unit employees.

B) Exception − Any deviation is a special salary adjustment (see subsection (e)).

3) Reevaluation – If a higher pay grade is assigned to a class, the employee occupying the position in the class shall be advanced to the lowest step in the new grade that represents an increase in pay. If an employee becomes eligible for a satisfactory performance increase as a result of the reevaluation, a one-step increase will be granted immediately. The reevaluation shall not change the creditable service date if the increase is less than one step for the bargaining unit employees.

4) Separation and Subsequent Appointment – Upon separation from a position of a given class and appointment within four calendar days to a position in a higher pay grade, an increase shall be given under the conditions and requirements applicable to promotions (see subsection (d)(1)).

5) Reclassification – If the class to which the position is being moved has a higher pay grade, the employee's base salary is advanced to the salary in the new pay grade that represents the least increase in pay. If this new salary is less than the difference between Step 7 and Step 8 in the new pay grade and the employee has been paid the base salary in Step 8 of the previous pay grade for longer than one year, the new salary is advanced one step from the salary in the new pay grade representing the least increase.

e) Adjustment – An employee may receive an upward adjustment in the employee's base salary for the purpose of correcting a previous error, oversight or when the best interest of the agency and the State of Illinois will be served. Adjustments shall have the prior approval of the Director of Central Management Services. An adjustment at the time of entrance into State government shall have supporting documentation in the candidate's CMS employment application (CMS-100). In determining the appropriateness of a request for a salary adjustment by an employing agency, the Director of Central Management Services shall consider whether the need for the adjustment is substantial, whether the action is consistent with the treatment of other similar situations, and whether the action is equitable in view of the particular circumstances prompting the request. The Director of Central Management Services' approval of an adjustment at the time of entrance into State government shall be based on the candidate's documented directly-related education and experience exceeding the minimum requirements in the class specification, prior base salary history, staffing needs and requirements of the employing agency, and labor market influences on the recruitment for the position classification or position. The adjustment shall not change the creditable service date if the increase is less than one step for the bargaining unit employees.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

SUBPART B: SCHEDULE OF RATES

Section 310.220 Negotiated Rate

a) Rates by Geographic Area, Agency or Agency Area − The rate of pay for a class in any specific area or agency, or in a specific area for an agency, is established and approved by the Director of Central Management Services after having conducted negotiations for this purpose, or as certified as being correct and reported to the Director of Central Management Services by the Director of the Illinois Department of Labor for designated classifications.

b) Rates for Positions Excluded from Bargaining Unit Representation − An employee occupying a position in a class normally subject to contract, but whose position is excluded from the bargaining unit, shall be assigned to the Merit Compensation System (Subpart C) and receive the rates, within the Merit Compensation System Salary Schedule (Appendix D) based on the salary range assigned to the classification title in Section 310.410~~, an out-of-state rate assigned to the classification title in Section 310.495~~ or within the Broad-Band Pay Range Classes Salary Schedule (Appendix G) based on the salary range assigned to the classification title.

c) Rates for Higher Duties − As provided in certain collective bargaining agreements, an employee may be paid at an appropriate higher rate when assigned to perform the duties of a higher level position. Eligibility for and the amount of this pay will be as provided in the contract.

d) Promotion from Step 8 − The employee shall be paid as provided in Section 310.80(d)(1)(A)(ii).

e) To Locate Rates − The negotiated rates of pay for classifications in specified operating agencies, in specified agency facilities or with specified duties shall be as indicated in Appendix A, unless the rates are red-circled~~ or frozen~~.

f) Red-Circled Rates – Red-circled rates are the negotiated or arbitrator assigned base salaries not otherwise on a step in the pay grade assigned to a classification or in the Pay Plan. The base salaries may be above the pay grade's maximum base salary or between two base salaries on consecutive steps. An employee who takes a position in a Trainee Program (80 Ill. Adm. Code 302.170) classification that represents a reduction when comparing classifications (Section 310.45) shall

receive the higher amount of either the in-hire rate or the base salary red-circled at the amount of the former classification. Upon completion of a trainee period, the employee who is promoted to a targeted title shall receive the rate on a step that results in a minimum of one dollar increase based on the difference between the two steps, which the red-circled rate is between, added to the red-circled rate. If through negotiation of a classification assignment to a pay grade where the base salary exceeds Step 8, the base salary shall be red-circled at its current rate and may receive contractual adjustments.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

SUBPART C: MERIT COMPENSATION SYSTEM

Section 310.410 Jurisdiction

The Merit Compensation System shall apply to classes of positions, or positions excluded from bargaining unit representation, designated below and Broad-Band classes in Appendix G. In addition, the classes are listed in the ALPHABETIC INDEX OF POSITION TITLES. Also see Section 310.495 for the application of the Merit Compensation System for those Broad-Band titles listed with their salary ranges in Appendix G.

Title	Title Code	Salary Range
Account Clerk I	00111	MS-03
Account Clerk II	00112	MS-04
Account Technician I	00115	MS-07
Account Technician II	00116	MS-09
Account Technician Trainee	00118	MS-04
Accountant	00130	MS-11
Accountant Advanced	00133	MS-14
Accountant Supervisor	00135	MS-19
Accounting and Fiscal Administration Career Trainee	00140	MS-09
Activity Program Aide I	00151	MS-04
Activity Program Aide II	00152	MS-05
Activity Therapist	00157	MS-12
Activity Therapist Coordinator	00160	MS-16
Activity Therapist Supervisor	00163	MS-23
Actuarial Assistant	00187	MS-14

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Actuarial Examiner	00195	MS-14
Actuarial Examiner Trainee	00196	MS-10
Actuarial Senior Examiner	00197	MS-21
Actuary I	00201	MS-23
Actuary II	00202	MS-31
Actuary III	00203	MS-33
Administrative Assistant I	00501	MS-16
Administrative Assistant II	00502	MS-21
Administrative Services Worker Trainee	00600	MS-02
Agricultural Executive	00800	MS-23
Agricultural Land and Water Resources Supervisor	00811	MS-25
Agricultural Market News Assistant	00804	MS-09
Agricultural Marketing Generalist	00805	MS-11
Agricultural Marketing Reporter	00807	MS-19
Agricultural Marketing Representative	00810	MS-19
Agricultural Products Promoter	00815	MS-10
Agriculture Land and Water Resource Specialist I	00831	MS-11
Agriculture Land and Water Resource Specialist II	00832	MS-16
Agriculture Land and Water Resource Specialist III	00833	MS-23
Aircraft Dispatcher	00951	MS-09
Aircraft Lead Dispatcher	00952	MS-11
Aircraft Pilot I	00955	MS-21
Aircraft Pilot II	00956	MS-28
Aircraft Pilot II − Dual Rating	00957	MS-29
Animal and Animal Products Investigator	01072	MS-11
Animal and Animal Products Investigator Trainee	01075	MS-09
Apiary Inspector	01215	MS-03
Apparel/Dry Goods Specialist I	01231	MS-04
Apparel/Dry Goods Specialist II	01232	MS-05
Apparel/Dry Goods Specialist III	01233	MS-10
Appraisal Specialist I	01251	MS-11
Appraisal Specialist II	01252	MS-14
Appraisal Specialist III	01253	MS-19
Appraisal Specialist Trainee	01255	MS-09
Arbitrator	01401	MS-33
Architect	01440	MS-28
Arson Investigations Trainee	01485	MS-12
Arson Investigator I	01481	MS-15

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Arson Investigator II	01482	MS-20
Arts Council Associate	01523	MS-09
Arts Council Program Coordinator	01526	MS-19
Arts Council Program Representative	01527	MS-12
Assignment Coordinator	01530	MS-23
Assistant Automotive Shop Supervisor	01565	MS-11
Assistant Reimbursement Officer	02424	MS-05
Audio Visual Technician I	03501	MS-04
Audio Visual Technician II	03502	MS-06
Auto and Body Repairer	03680	MS-13
Automotive Attendant I	03696	MS-03
Automotive Attendant II	03697	MS-03
Automotive Mechanic	03700	MS-13
Automotive Parts Warehouse Specialist	03734	MS-11
Automotive Parts Warehouser	03730	MS-11
Automotive Shop Supervisor	03749	MS-18
Bank Examiner I	04131	MS-14
Bank Examiner II	04132	MS-21
Bank Examiner III	04133	MS-28
Behavioral Analyst Associate	04355	MS-12
Behavioral Analyst I	04351	MS-16
Behavioral Analyst II	04352	MS-21
Blasting Expert	04720	MS-27
Blasting Specialist	04725	MS-25
Blasting Supervisor	04730	MS-29
Boat Safety Inspection Supervisor	04850	MS-22
Boiler Safety Specialist	04910	MS-26
Breath Alcohol Analysis Technician	05170	MS-15
Bridge Mechanic	05310	MS-17
Bridge Tender	05320	MS-18
Building Construction Inspector I	05541	MS-18
Building Construction Inspector II	05542	MS-20
Building Services Worker	05616	MS-05
Building/Grounds Laborer	05598	MS-08
Building/Grounds Lead I	05601	MS-10
Building/Grounds Lead II	05602	MS-12
Building/Grounds Maintenance Worker	05613	MS-09
Building/Grounds Supervisor	05605	MS-12

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Business Administrative Specialist	05810	MS-14
Business Manager	05815	MS-19
Buyer	05900	MS-19
Buyer Assistant	05905	MS-07
Cancer Registrar I	05951	MS-11
Cancer Registrar II	05952	MS-14
Cancer Registrar III	05953	MS-23
Cancer Registrar Assistant Manager	05954	MS-27
Cancer Registrar Manager	05955	MS-31
Canine Specialist	06500	MS-20
Capital Development Board Account Technician	06515	MS-08
Capital Development Board Art In Architecture Technician	06533	MS-09
Capital Development Board Construction Support Analyst	06520	MS-08
Capital Development Board Media Technician	06525	MS-11
Capital Development Board Project Technician	06530	MS-09
Cartographer III	06673	MS-28
Chaplain I	06901	MS-14
Chaplain II	06902	MS-21
Check Issuance Machine Operator	06920	MS-06
Check Issuance Machine Supervisor	06925	MS-08
Chemist I	06941	MS-14
Chemist II	06942	MS-21
Chemist III	06943	MS-25
Child Development Aide	07184	MS-07
Child Protection Advanced Specialist	07161	MS-21
Child Protection Associate Specialist	07162	MS-14
Child Protection Specialist	07163	MS-19
Child Support Specialist I	07198	MS-14
Child Support Specialist II	07199	MS-16
Child Support Specialist Trainee	07200	MS-09
Child Welfare Administrative Case Reviewer	07190	MS-28
Child Welfare Advanced Specialist	07215	MS-21
Child Welfare Associate Specialist	07216	MS-14
Child Welfare Court Facilitator	07196	MS-28
Child Welfare Nurse Specialist	07197	MS-22
Child Welfare Senior Specialist	07217	MS-28

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Child Welfare Specialist	07218	MS-19
Child Welfare Staff Development Coordinator I	07201	MS-16
Child Welfare Staff Development Coordinator II	07202	MS-21
Child Welfare Staff Development Coordinator III	07203	MS-23
Child Welfare Staff Development Coordinator IV	07204	MS-28
Children and Family Service Intern, Option 1	07241	MS-09
Children and Family Service Intern, Option 2	07242	MS-12
Civil Engineer I	07601	MS-22
Civil Engineer II	07602	MS-26
Civil Engineer III	07603	MS-30
Civil Engineer IV	07604	MS-31
Civil Engineer Trainee	07607	MS-16
Clerical Trainee	08050	MS-01
Clinical Laboratory Associate	08200	MS-05
Clinical Laboratory Phlebotomist	08213	MS-04
Clinical Laboratory Technician I	08215	MS-07
Clinical Laboratory Technician II	08216	MS-09
Clinical Laboratory Technologist I	08220	MS-19
Clinical Laboratory Technologist II	08221	MS-21
Clinical Laboratory Technologist Trainee	08229	MS-11
Clinical Pharmacist	08235	MS-32
Clinical Psychologist	08250	MS-29
Clinical Psychology Associate	08255	MS-19
Clinical Services Supervisor	08260	MS-31
Commerce Commission Police Officer I	08451	MS-18
Commerce Commission Police Officer II	08452	MS-22
Commerce Commission Police Officer Trainee	08455	MS-10
Commerce Commission Police Sergeant	08457	MS-24
Commodities Inspector	08770	MS-08
Communications Dispatcher	08815	MS-06
Communications Equipment Technician I	08831	MS-16
Communications Equipment Technician II	08832	MS-21
Communications Equipment Technician III	08833	MS-23
Communications Systems Specialist	08860	MS-29
Community Management Specialist I	08891	MS-12
Community Management Specialist II	08892	MS-16
Community Management Specialist III	08893	MS-21
Community Planner I	08901	MS-12

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Community Planner II	08902	MS-16
Community Planner III	08903	MS-21
Compliance Officer	08919	MS-11
Conservation Education Representative	09300	MS-09
Conservation Grant Administrator I	09311	MS-19
Conservation Grant Administrator II	09312	MS-23
Conservation Grant Administrator III	09313	MS-28
Conservation Police Lieutenant	09339	MS-23
Conservation Police Officer I	09341	MS-18
Conservation Police Officer II	09342	MS-19
Conservation Police Officer Trainee	09345	MS-06
Conservation Police Sergeant	09347	MS-22
Conservation/Historic Preservation Worker	09317	MS-01
Construction Program Assistant	09525	MS-09
Construction Supervisor I	09561	MS-10
Construction Supervisor II	09562	MS-14
Cook I	09601	MS-04
Cook II	09602	MS-07
Correctional Casework Supervisor	09655	MS-25
Correctional Counselor I	09661	MS-12
Correctional Counselor II	09662	MS-16
Correctional Counselor III	09663	MS-21
Correctional Lieutenant	09673	MS-24
Correctional Officer	09675	MS-11
Correctional Officer Trainee	09676	MS-08
Correctional Sergeant	09717	MS-16
Corrections Apprehension Specialist	09750	MS-21
Corrections Clerk I	09771	MS-11
Corrections Clerk II	09772	MS-13
Corrections Clerk III	09773	MS-18
Corrections Food Service Supervisor I	09793	MS-13
Corrections Food Service Supervisor II	09794	MS-18
Corrections Food Service Supervisor III	09795	MS-21
Corrections Grounds Supervisor	09796	MS-16
Corrections Identification Supervisor	09800	MS-24
Corrections Identification Technician	09801	MS-13
Corrections Industries Marketing Representative	09803	MS-16
Corrections Industry Lead Worker	09805	MS-16

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Corrections Industry Supervisor	09807	MS-21
Corrections Laundry Manager I	09808	MS-18
Corrections Laundry Manager II	09809	MS-20
Corrections Leisure Activities Specialist I	09811	MS-12
Corrections Leisure Activities Specialist II	09812	MS-16
Corrections Leisure Activities Specialist III	09813	MS-21
Corrections Leisure Activities Specialist IV	09814	MS-25
Corrections Locksmith	09818	MS-16
Corrections Maintenance Craftsman	09821	MS-16
Corrections Maintenance Supervisor	09822	MS-20
Corrections Maintenance Worker	09823	MS-12
Corrections Medical Technician	09824	MS-12
Corrections Nurse I	09825	MS-20
Corrections Nurse II	09826	MS-25
Corrections Parole Agent	09842	MS-16
Corrections Residence Counselor I	09837	MS-13
Corrections Residence Counselor II	09838	MS-20
Corrections Senior Parole Agent	09844	MS-21
Corrections Supply Supervisor I	09861	MS-13
Corrections Supply Supervisor II	09862	MS-18
Corrections Supply Supervisor III	09863	MS-21
Corrections Transportation Officer I	09871	MS-13
Corrections Transportation Officer II	09872	MS-20
Corrections Utilities Operator	09875	MS-16
Corrections Vocational Instructor	09879	MS-16
Corrections Vocational School Supervisor	09880	MS-20
Court Reporter	09900	MS-12
Court Reporter Supervisor	09903	MS-26
Crime Scene Investigator	09980	MS-25
Criminal Intelligence Analyst I	10161	MS-19
Criminal Intelligence Analyst II	10162	MS-23
Criminal Intelligence Analyst Specialist	10165	MS-28
Criminal Justice Specialist I	10231	MS-14
Criminal Justice Specialist II	10232	MS-23
Criminal Justice Specialist Trainee	10236	MS-10
Curator Of The Lincoln Collection	10750	MS-14
Data Processing Administrative Specialist	11415	MS-11
Data Processing Assistant	11420	MS-04

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Data Processing Operator	11425	MS-03
Data Processing Operator Trainee	11428	MS-02
Data Processing Specialist	11430	MS-09
Data Processing Supervisor I	11435	MS-08
Data Processing Supervisor II	11436	MS-11
Data Processing Supervisor III	11437	MS-19
Data Processing Technician	11440	MS-06
Data Processing Technician Trainee	11443	MS-04
Day Care Licensing Representative I	11471	MS-14
Day Care Licensing Representative II	11472	MS-19
Deck Hand	11500	MS-15
Dental Assistant	11650	MS-07
Dental Hygienist	11700	MS-11
Dentist I	11751	MS-29
Dentist II	11752	MS-33
Developmental Disabilities Council Program Planner I	12361	MS-09
Developmental Disabilities Council Program Planner II	12362	MS-14
Developmental Disabilities Council Program Planner III	12363	MS-19
Dietary Manager I	12501	MS-14
Dietary Manager II	12502	MS-19
Dietitian	12510	MS-12
Disability Appeals Officer	12530	MS-28
Disability Claims Adjudicator I	12537	MS-14
Disability Claims Adjudicator II	12538	MS-19
Disability Claims Adjudicator Trainee	12539	MS-10
Disability Claims Analyst	12540	MS-25
Disability Claims Specialist	12558	MS-21
Disaster Services Planner	12585	MS-21
Document Examiner	12640	MS-28
Drafting Worker	12749	MS-08
Drug Compliance Investigator	12778	MS-31
Economic Development Representative I	12931	MS-16
Economic Development Representative II	12932	MS-21
Economic Development Representative Trainee	12939	MS-10
Educational Diagnostician	12965	MS-09
Educational Media Program Specialist	12980	MS-16
Educator	13100	MS-26
Educator − Provisional	13105	MS-10

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Educator Aide	13130	MS-08
Educator Trainee	13148	MS-09
Electrical Engineer	13180	MS-28
Electroencephalograph Technician	13300	MS-05
Electronic Equipment Installer/Repairer	13340	MS-07
Electronic Equipment Installer/Repairer Lead Worker	13345	MS-09
Electronics Technician	13360	MS-12
Elevator Inspector	13495	MS-21
Elevator Operator	13500	MS-05
Emergency Response Lead Telecommunicator	13540	MS-10
Emergency Response Telecommunicator	13543	MS-08
Employment Security Field Office Supervisor	13600	MS-23
Employment Security Manpower Representative I	13621	MS-09
Employment Security Manpower Representative II	13622	MS-11
Employment Security Program Representative	13650	MS-11
Employment Security Program Representative − Intermittent	13651	MS-11
Employment Security Service Representative	13667	MS-14
Employment Security Specialist I	13671	MS-11
Employment Security Specialist II	13672	MS-14
Employment Security Specialist III	13673	MS-21
Employment Security Tax Auditor I	13681	MS-16
Employment Security Tax Auditor II	13682	MS-21
End-User Computer Services Specialist I	13691	MS-24
End-User Computer Services Specialist II	13692	MS-28
End-User Computer Systems Analyst	13693	MS-30
Energy and Natural Resources Specialist I	13711	MS-12
Energy and Natural Resources Specialist II	13712	MS-16
Energy and Natural Resources Specialist III	13713	MS-21
Energy and Natural Resources Specialist Trainee	13715	MS-09
Engineering Technician I	13731	MS-10
Engineering Technician II	13732	MS-13
Engineering Technician III	13733	MS-20
Engineering Technician IV	13734	MS-30
Environmental Engineer I	13751	MS-12
Environmental Engineer II	13752	MS-16
Environmental Engineer III	13753	MS-21
Environmental Engineer IV	13754	MS-28

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Environmental Equipment Operator I	13761	MS-09
Environmental Equipment Operator II	13762	MS-11
Environmental Health Specialist I	13768	MS-11
Environmental Health Specialist II	13769	MS-14
Environmental Health Specialist III	13770	MS-19
Environmental Protection Associate	13785	MS-09
Environmental Protection Engineer I	13791	MS-12
Environmental Protection Engineer II	13792	MS-16
Environmental Protection Engineer III	13793	MS-21
Environmental Protection Engineer IV	13794	MS-28
Environmental Protection Geologist I	13801	MS-12
Environmental Protection Geologist II	13802	MS-16
Environmental Protection Geologist III	13803	MS-21
Environmental Protection Legal Investigator I	13811	MS-10
Environmental Protection Legal Investigator II	13812	MS-11
Environmental Protection Legal Investigator Specialist	13815	MS-13
Environmental Protection Specialist I	13821	MS-11
Environmental Protection Specialist II	13822	MS-14
Environmental Protection Specialist III	13823	MS-19
Environmental Protection Specialist IV	13824	MS-28
Environmental Protection Technician I	13831	MS-05
Environmental Protection Technician II	13832	MS-07
Equal Pay Specialist	13837	MS-16
Equine Investigator	13840	MS-09
Executive I	13851	MS-19
Executive II	13852	MS-23
Executive Secretary I	14031	MS-08
Executive Secretary II	14032	MS-11
Executive Secretary III	14033	MS-14
Explosives Inspector I	14051	MS-11
Explosives Inspector II	14052	MS-18
Facility Assistant Fire Chief	14430	MS-10
Facility Fire Chief	14433	MS-13
Facility Fire Safety Coordinator	14435	MS-09
Facility Firefighter	14439	MS-07
Ferry Operator I	14801	MS-18
Ferry Operator II	14802	MS-19
Financial Institutions Examiner I	14971	MS-14

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Financial Institutions Examiner II	14972	MS-21
Financial Institutions Examiner III	14973	MS-28
Financial Institutions Examiner Trainee	14978	MS-10
Fingerprint Technician	15204	MS-10
Fingerprint Technician Supervisor	15208	MS-18
Fingerprint Technician Trainee	15209	MS-05
Fire Certification Specialist I	15281~~15285~~	MS-16
Fire Certification Specialist II	15282	MS-18
Fire Certification Specialist Supervisor	15283	MS-22
Fire Prevention Inspector I	15316	MS-13
Fire Prevention Inspector II	15317	MS-20
Fire Prevention Inspector Trainee	15320	MS-10
Fire Protection Specialist I	15351	MS-14
Flight Safety Coordinator	15640	MS-28
Florist II	15652	MS-08
Foreign Service Economic Development Executive I	15871	MS-32
Foreign Service Economic Development Executive II	15872	MS-34
Foreign Service Economic Development Representative	15875	MS-30
Forensic Science Administrator I	15911	MS-31
Forensic Science Administrator II	15912	MS-32
Forensic Scientist I	15891	MS-19
Forensic Scientist II	15892	MS-23
Forensic Scientist III	15893	MS-28
Forensic Scientist Trainee	15897	MS-12
Gaming Licensing Analyst	17171	MS-10
Gaming Senior Special Agent	17191	MS-29
Gaming Special Agent	17192	MS-21
Gaming Special Agent Trainee	17195	MS-11
Geographic Information Specialist I	17271	MS-21
Geographic Information Specialist II	17272	MS-29
Geographic Information Trainee	17276	MS-12
Governmental Career Trainee	17325	MS-09
Graduate Pharmacist	17345	MS-23
Graphic Arts Designer	17366	MS-11
Graphic Arts Designer Advanced	17370	MS-14
Graphic Arts Designer Supervisor	17365	MS-19
Graphic Arts Technician	17400	MS-09
Grounds Supervisor	17549	MS-18

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Guard I	17681	MS-04
Guard II	17682	MS-06
Guard III	17683	MS-09
Guard Supervisor	17685	MS-11
Guardianship Representative	17710	MS-16
Guardianship Supervisor	17720	MS-24
Habilitation Program Coordinator	17960	MS-16
Handicapped Services Representative I	17981	MS-08
Health Facilities Surveillance Nurse	18150	MS-22
Health Facilities Surveyor I	18011	MS-14
Health Facilities Surveyor II	18012	MS-21
Health Facilities Surveyor III	18013	MS-23
Health Information Associate	18045	MS-07
Health Information Technician	18047	MS-09
Health Services Investigator I, Option A − General	18181	MS-21
Health Services Investigator I, Option B − Controlled Substance Inspector	18182	MS-23
Health Services Investigator II, Option A − General	18185	MS-28
Health Services Investigator II, Option B − Controlled Substance Inspector	18186	MS-28
Health Services Investigator II, Option C − Pharmacy	18187	MS-32
Health Services Investigator II, Option D − Pharmacy/Controlled Substance Inspector	18188	MS-32
Hearing and Speech Advanced Specialist	18227	MS-28
Hearing and Speech Associate	18231	MS-19
Hearing and Speech Specialist	18233	MS-23
Hearing and Speech Technician I	18261	MS-04
Hearing and Speech Technician II	18262	MS-06
Hearings Referee	18300	MS-29
Hearings Referee − Intermittent	18301	MS-29
Heavy Construction Equipment Operator	18465	MS-18
Highway Construction Supervisor I	18525	MS-25
Highway Construction Supervisor II	18526	MS-30
Highway Maintainer	18639	MS-18
Highway Maintenance Lead Worker	18659	MS-18
Historical Documents Conservator I	18981	MS-10
Historical Exhibits Designer	18985	MS-12
Historical Library Chief Of Acquisitions	18987	MS-21

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Historical Research Editor II	19002	MS-11
Historical Research Specialist	19008	MS-23
Housekeeper II	19602	MS-03
Human Relations Representative	19670	MS-14
Human Resources Assistant	19690	MS-05
Human Resources Associate	19691	MS-08
Human Resources Trainee	19694	MS-04
Human Rights Investigator I	19774	MS-14
Human Rights Investigator II	19775	MS-19
Human Rights Investigator III	19776	MS-21
Human Rights Mediation Supervisor	19769	MS-23
Human Rights Mediator	19771	MS-16
Human Rights Specialist I	19778	MS-11
Human Rights Specialist II	19779	MS-14
Human Rights Specialist III	19780	MS-19
Human Services Casework Manager	19788	MS-23
Human Services Caseworker	19785	MS-14
Human Services Grants Coordinator I	19791	MS-11
Human Services Grants Coordinator II	19792	MS-16
Human Services Grants Coordinator III	19793	MS-23
Human Services Grants Coordinator Trainee	19796	MS-09
Human Services Sign Language Interpreter	19810	MS-14
Iconographer	19880	MS-09
Industrial and Community Development Representative I	21051	MS-16
Industrial and Community Development Representative II	21052	MS-21
Industrial Commission Reporter	21080	MS-14
Industrial Commission Technician	21095	MS-08
Industrial Services Consultant I	21121	MS-11
Industrial Services Consultant II	21122	MS-14
Industrial Services Consultant Trainee	21125	MS-08
Industrial Services Hygienist	21127	MS-21
Industrial Services Hygienist Technician	21130	MS-14
Industrial Services Hygienist Trainee	21133	MS-09
Information Services Intern	21160	MS-12
Information Services Specialist I	21161	MS-16
Information Services Specialist II	21162	MS-21
Information Systems Analyst I	21165	MS-25
Information Systems Analyst II	21166	MS-29

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Information Systems Analyst III	21167	MS-32
Information Technology/Communications Systems Specialist I	21216	MS-21
Information Technology/Communications Systems Specialist II	21217	MS-31
Inhalation Therapist	21259	MS-05
Inhalation Therapy Supervisor	21260	MS-08
Institutional Helper	21460	MS-05
Institutional Maintenance Worker	21465	MS-05
Instrument Designer	21500	MS-19
Insurance Analyst I	21561	MS-06
Insurance Analyst II	21562	MS-09
Insurance Analyst III	21563	MS-11
Insurance Analyst IV	21564	MS-14
Insurance Analyst Trainee	21566	MS-04
Insurance Company Claims Examiner I	21601	MS-16
Insurance Company Claims Examiner II	21602	MS-21
Insurance Company Field Staff Examiner	21608	MS-14
Insurance Company Financial Examiner Trainee	21610	MS-10
Insurance Performance Examiner I	21671	MS-11
Insurance Performance Examiner II	21672	MS-16
Insurance Performance Examiner III	21673	MS-23
Intermittent Clerk	21686	MS-02
Intermittent Laborer (Maintenance)	21687	MS-08
Intermittent Unemployment Insurance Representative	21689	MS-09
Intermittent Unemployment Insurance Technician	21690	MS-04
Internal Auditor I	21721	MS-16
Internal Auditor Trainee	21726	MS-09
Internal Security Investigator I	21731	MS-19
Internal Security Investigator II	21732	MS-25
International Marketing Representative I	21761	MS-11
Janitor I	21951	MS-13
Janitor II	21952	MS-14
Juvenile Justice Chief of Security	21965	MS-31
Juvenile Justice Specialist	21971	MS-20
Juvenile Justice Specialist Intern	21976	MS-13
Juvenile Justice Supervisor	21980	MS-27
Juvenile Justice Youth and Family Specialist Option 1	21991	MS-19

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Juvenile Justice Youth and Family Specialist Option 2	21992	MS-23
Juvenile Justice Youth and Family Specialist Supervisor	21995	MS-28
Kidcare Supervisor	22003	MS-23
Labor Conciliator	22750	MS-23
Labor Maintenance Lead Worker	22809	MS-16
Laboratory Assistant	22995	MS-03
Laboratory Associate I	22997	MS-07
Laboratory Associate II	22998	MS-09
Laboratory Equipment Specialist	22990	MS-19
Laboratory Quality Specialist I	23021	MS-21
Laboratory Quality Specialist II	23022	MS-25
Laboratory Research Scientist	23025	MS-29
Laboratory Research Specialist I	23027	MS-21
Laboratory Research Specialist II	23028	MS-25
Laborer (Maintenance)	23080	MS-15
Land Acquisition Agent I	23091	MS-12
Land Acquisition Agent II	23092	MS-19
Land Acquisition Agent III	23093	MS-25
Land Reclamation Specialist I	23131	MS-11
Land Reclamation Specialist II	23132	MS-16
Landscape Architect	23145	MS-28
Landscape Planner	23150	MS-21
Laundry Manager I	23191	MS-10
Legal Research Assistant	23350	MS-10
Liability Claims Adjuster I	23371	MS-11
Liability Claims Adjuster II	23372	MS-19
Liability Claims Adjuster Trainee	23375	MS-09
Librarian I	23401	MS-14
Librarian II	23402	MS-19
Library Aide I	23421	MS-03
Library Aide II	23422	MS-04
Library Aide III	23423	MS-05
Library Associate	23430	MS-09
Library Technical Assistant	23450	MS-07
Licensed Practical Nurse I	23551	MS-09
Licensed Practical Nurse II	23552	MS-10
Licensing Assistant	23568	MS-05
Licensing Investigator I	23571	MS-10

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Licensing Investigator II	23572	MS-13
Licensing Investigator III	23573	MS-15
Licensing Investigator IV	23574	MS-20
Life Sciences Career Trainee	23600	MS-09
Liquor Control Special Agent I	23751	MS-13
Liquor Control Special Agent II	23752	MS-14
Local Historical Services Representative	24000	MS-16
Local Housing Advisor I	24031	MS-11
Local Housing Advisor II	24032	MS-14
Local Housing Advisor III	24033	MS-19
Local Revenue and Fiscal Advisor I	24101	MS-12
Local Revenue and Fiscal Advisor II	24102	MS-16
Local Revenue and Fiscal Advisor III	24103	MS-21
Lock and Dam Tender	24290	MS-07
Locksmith	24300	MS-16
Lottery Commodities Distributor II	24402	MS-09
Lottery Regional Coordinator	24504	MS-21
Lottery Sales Representative	24515	MS-14
Lottery Telemarketing Representative	24520	MS-06
Maintenance Equipment Operator	25020	MS-18
Maintenance Worker	25500	MS-16
Management Operations Analyst I	25541	MS-19
Management Operations Analyst II	25542	MS-23
Management Operations Analyst Trainee	25545	MS-12
Management Systems Specialist	25583	MS-25
Manpower Planner I	25591	MS-11
Manpower Planner II	25592	MS-16
Manpower Planner III	25593	MS-23
Manpower Planner Trainee	25597	MS-09
Manuscripts Manager	25610	MS-21
Meat and Poultry Inspector	26070	MS-10
Meat and Poultry Inspector Supervisor	26073	MS-13
Meat and Poultry Inspector Trainee	26075	MS-07
Mechanical Engineer I	26201	MS-12
Mechanical Engineer II	26202	MS-16
Mechanical Engineer III	26203	MS-21
Medical Administrator I Option C	26400	MS-60
Medical Administrator I Option D	26401	MS-62

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Medical Administrator II Option C	26402	MS-61
Medical Administrator II Option D	26403	MS-64
Medical Administrator III	26404	MS-65
Medical Administrator IV	26405	MS-66
Medical Administrator V	26406	MS-67
Medical Assistance Consultant I	26501	MS-10
Medical Assistance Consultant II	26502	MS-14
Medical Assistance Consultant III	26503	MS-21
Mental Health Administrator I	26811	MS-19
Mental Health Administrator II	26812	MS-23
Mental Health Administrator Trainee	26817	MS-14
Mental Health Program Administrator	26908	MS-63
Mental Health Recovery Support Specialist I	26921	MS-16
Mental Health Recovery Support Specialist II	26922	MS-19
Mental Health Specialist I	26924	MS-09
Mental Health Specialist II	26925	MS-11
Mental Health Specialist III	26926	MS-14
Mental Health Specialist Trainee	26928	MS-08
Mental Health Technician I	27011	MS-04
Mental Health Technician II	27012	MS-05
Mental Health Technician III	27013	MS-06
Mental Health Technician IV	27014	MS-07
Mental Health Technician V	27015	MS-08
Mental Health Technician VI	27016	MS-09
Mental Health Technician Trainee	27020	MS-03
Meteorologist	27120	MS-19
Methods and Procedures Advisor I	27131	MS-11
Methods and Procedures Advisor II	27132	MS-14
Methods and Procedures Advisor III	27133	MS-23
Methods and Procedures Career Associate I	27135	MS-08
Methods and Procedures Career Associate II	27136	MS-09
Methods and Procedures Career Associate Trainee	27137	MS-06
Metrologist Associate	27146	MS-12
Microbiologist I	27151	MS-14
Microbiologist II	27152	MS-21
Microfilm Laboratory Technician I	27175	MS-04
Microfilm Laboratory Technician II	27176	MS-06
Microfilm Operator I	27181	MS-03

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Microfilm Operator II	27182	MS-04
Microfilm Operator III	27183	MS-05
Mine Rescue Station Assistant	28150	MS-07
Motorist Assistance Specialist	28490	MS-05
Musician	28805	MS-05
Natural Resource Technician I	28851	MS-07
Natural Resource Technician II	28852	MS-10
Natural Resources Advanced Specialist	28833	MS-23
Natural Resources Coordinator	28831	MS-12
Natural Resources Education Program Coordinator	28834	MS-23
Natural Resources Grant Coordinator	28835	MS-20
Natural Resources Manager I	28836	MS-23
Natural Resources Manager II	28837	MS-26
Natural Resources Manager III	28838	MS-30
Natural Resources Site Manager I	28841	MS-23
Natural Resources Site Manager II	28842	MS-26
Natural Resources Specialist	28832	MS-19
Nursing Act Assistant Coordinator	29731	MS-25
Nutritionist	29820	MS-19
Occupational Therapist	29900	MS-16
Occupational Therapist Program Coordinator	29908	MS-21
Occupational Therapist Supervisor	29910	MS-25
Office Administrative Specialist	29990	MS-09
Office Administrator I	29991	MS-04
Office Administrator II	29992	MS-06
Office Administrator III	29993	MS-08
Office Administrator IV	29994	MS-11
Office Administrator V	29995	MS-12
Office Aide	30005	MS-02
Office Assistant	30010	MS-04
Office Associate	30015	MS-05
Office Clerk	30020	MS-03
Office Coordinator	30025	MS-06
Office Occupations Trainee	30075	MS-01
Office Specialist	30080	MS-08
Optometrist	30300	MS-11
Oral Health Consultant	30317	MS-19
Paralegal Assistant	30860	MS-11

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Pension and Death Benefits Technician I	30961	MS-09
Pension and Death Benefits Technician II	30962	MS-21
Pest Control Operator	31810	MS-07
Pharmacy Lead Technician	32009	MS-06
Pharmacy Services Coordinator	32010	MS-32
Pharmacy Technician	32011	MS-04
Photographer	32080	MS-11
Photographic Technician I	32091	MS-08
Photographic Technician II	32092	MS-11
Photographic Technician III	32093	MS-12
Physical Therapist	32145	MS-16
Physical Therapist Program Coordinator	32153	MS-21
Physical Therapy Aide I	32191	MS-03
Physical Therapy Aide II	32192	MS-05
Physical Therapy Aide III	32193	MS-08
Physician	32200	MS-36
Physician Assistant	32210	MS-27
Physician Specialist − Option A	32221	MS-37
Physician Specialist − Option B	32222	MS-38
Physician Specialist − Option C	32223	MS-61
Physician Specialist − Option D	32224	MS-63
Physician Specialist − Option E	32225	MS-65
Plant and Pesticide Specialist I	32501	MS-15
Plant and Pesticide Specialist II	32502	MS-20
Plant and Pesticide Specialist Supervisor	32506	MS-20
Plumbing Consultant	32910	MS-28
Plumbing Inspector	32915	MS-22
Podiatrist	32960	MS-11
Police Lieutenant	32977	MS-31
Police Officer I	32981	MS-15
Police Officer II	32982	MS-20
Police Officer III	32983	MS-24
Police Officer Trainee	32985	MS-06
Police Training Specialist	32990	MS-16
Polygraph Examiner I	33001	MS-20
Polygraph Examiner II	33002	MS-24
Polygraph Examiner III	33003	MS-28
Polygraph Examiner Trainee	33005	MS-12

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Power Shovel Operator	33360	MS-18
Private Secretary I	34201	MS-13
Private Secretary II	34202	MS-18
Procurement Representative	34540	MS-06
Products and Standards Inspector	34603	MS-11
Products and Standards Inspector Trainee	34605	MS-09
Program Integrity Auditor I	34631	MS-14
Program Integrity Auditor II	34632	MS-21
Program Integrity Auditor Trainee	34635	MS-09
Project Designer	34725	MS-21
Property and Supply Clerk I	34791	MS-03
Property and Supply Clerk II	34792	MS-04
Property and Supply Clerk III	34793	MS-05
Property Consultant	34900	MS-12
Psychologist Associate	35626	MS-12
Psychologist I	35611	MS-16
Psychologist II	35612	MS-23
Psychologist III	35613	MS-28
Psychology Intern	35660	MS-15
Public Administration Intern	35700	MS-11
Public Aid Eligibility Assistant	35825	MS-05
Public Aid Investigator	35870	MS-21
Public Aid Investigator Trainee	35874	MS-11
Public Aid Lead Casework Specialist	35880	MS-16
Public Aid Program Quality Analyst	35890	MS-21
Public Aid Quality Control Reviewer	35892	MS-16
Public Aid Quality Control Supervisor	35900	MS-21
Public Aid Staff Development Specialist I	36071	MS-12
Public Aid Staff Development Specialist II	36072	MS-16
Public Aid Staff Development Specialist III	36073	MS-22
Public Health Educator	36430	MS-21
Public Health Educator Associate	36434	MS-11
Public Health Program Specialist I	36611	MS-11
Public Health Program Specialist II	36612	MS-14
Public Health Program Specialist III	36613	MS-21
Public Health Program Specialist Trainee	36615	MS-09
Public Information Coordinator	36750	MS-19
Public Information Officer I	37001	MS-09

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Public Information Officer II	37002	MS-11
Public Information Officer III	37003	MS-21
Public Information Officer IV	37004	MS-25
Public Safety Inspector	37007	MS-14
Public Safety Inspector Trainee	37010	MS-07
Public Service Trainee	37025	MS-01
Race Track Maintainer I	37551	MS-10
Race Track Maintainer II	37552	MS-12
Radiologic Technologist	37500	MS-08
Radiologic Technologist Chief	37505	MS-17
Radiologic Technologist Program Coordinator	37507	MS-09
Railroad Safety Specialist I	37601	MS-21
Railroad Safety Specialist II	37602	MS-25
Railroad Safety Specialist III	37603	MS-29
Railroad Safety Specialist IV	37604	MS-32
Ranger	37725	MS-10
Real Estate Investigator	37730	MS-21
Real Estate Professions Examiner	37760	MS-28
Recreation Worker I	38001	MS-09
Recreation Worker II	38002	MS-11
Refrigeration and Air Conditioning Repairer	38119	MS-12
Registered Nurse − Advanced Practice	38135	MS-26
Registered Nurse I	38131	MS-18
Registered Nurse II	38132	MS-22
Rehabilitation Case Coordinator I	38141	MS-05
Rehabilitation Case Coordinator II	38142	MS-07
Rehabilitation Counselor	38145	MS-16
Rehabilitation Counselor Aide I	38155	MS-06
Rehabilitation Counselor Aide II	38156	MS-08
Rehabilitation Counselor Senior	38158	MS-21
Rehabilitation Counselor Trainee	38159	MS-12
Rehabilitation Services Advisor I	38176	MS-23
Rehabilitation Workshop Instructor I	38192	MS-05
Rehabilitation Workshop Instructor II	38193	MS-09
Rehabilitation Workshop Supervisor I	38194	MS-09
Rehabilitation Workshop Supervisor II	38195	MS-11
Rehabilitation Workshop Supervisor III	38196	MS-14
Rehabilitation/Mobility Instructor	38163	MS-21

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Rehabilitation/Mobility Instructor Trainee	38167	MS-12
Reimbursement Officer I	38199	MS-11
Reimbursement Officer II	38200	MS-14
Reproduction Service Supervisor I	38201	MS-10
Reproduction Service Supervisor II	38202	MS-18
Reproduction Service Technician I	38203	MS-03
Reproduction Service Technician II	38204	MS-06
Reproduction Service Technician III	38205	MS-08
Research Economist I	38207	MS-19
Research Fellow, Option B	38211	MS-19
Research Scientist I	38231	MS-10
Research Scientist II	38232	MS-14
Research Scientist III	38233	MS-23
Resident Physician	38270	MS-15
Residential Care Program Supervisor I	38271	MS-22
Residential Care Worker	38277	MS-09
Residential Care Worker Trainee	38279	MS-05
Resource Planner I	38281	MS-16
Resource Planner II	38282	MS-21
Resource Planner III	38283	MS-28
Retirement System Disability Specialist	38310	MS-21
Revenue Audit Supervisor	38369	MS-32
Revenue Auditor I	38371	MS-14
Revenue Auditor II	38372	MS-21
Revenue Auditor III	38373	MS-28
Revenue Auditor Trainee	38375	MS-09
Revenue Collection Officer I	38401	MS-12
Revenue Collection Officer II	38402	MS-16
Revenue Collection Officer III	38403	MS-21
Revenue Collection Officer Trainee	38405	MS-09
Revenue Computer Audit Specialist	38425	MS-29
Revenue Senior Special Agent	38557	MS-29
Revenue Special Agent	38558	MS-21
Revenue Special Agent Trainee	38565	MS-11
Revenue Tax Specialist I	38571	MS-09
Revenue Tax Specialist II	38572	MS-11
Revenue Tax Specialist III	38573	MS-16
Revenue Tax Specialist Trainee	38575	MS-07

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Safety Responsibility Analyst	38910	MS-09
Safety Responsibility Analyst Supervisor	38915	MS-11
School Psychologist	39200	MS-21
Security Guard I	39851	MS-13
Security Guard II	39852	MS-14
Security Officer	39870	MS-10
Security Officer Chief	39875	MS-13
Security Officer Lieutenant	39876	MS-11
Security Officer Sergeant	39877	MS-10
Security Therapy Aide I	39901	MS-10
Security Therapy Aide II	39902	MS-11
Security Therapy Aide III	39903	MS-13
Security Therapy Aide IV	39904	MS-16
Security Therapy Aide Trainee	39905	MS-06
Seed Analyst I	39951	MS-09
Seed Analyst II	39952	MS-10
Seed Analyst Trainee	39953	MS-07
Senior Ranger	40090	MS-11
Sex Offender Therapist I	40531	MS-16
Sex Offender Therapist II	40532	MS-21
Shift Supervisor	40800	MS-31
Sign Shop Foreman	41000	MS-12
Silk Screen Operator	41020	MS-17
Site Assistant Superintendent I	41071	MS-12
Site Assistant Superintendent II	41072	MS-16
Site Interpreter	41090	MS-07
Site Interpretive Coordinator	41093	MS-10
Site Security Officer	41115	MS-06
Site Services Specialist I	41117	MS-12
Site Services Specialist II	41118	MS-16
Site Superintendent I	41211	MS-20
Site Superintendent II	41212	MS-25
Site Superintendent III	41213	MS-29
Site Technician I	41131	MS-07
Site Technician II	41132	MS-09
Small Engine Mechanic	41150	MS-10
Social Service Aide I	41281	MS-05
Social Service Aide II	41282	MS-08

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Social Service Aide Trainee	41285	MS-03
Social Service Community Planner	41295	MS-08
Social Service Consultant I	41301	MS-19
Social Service Consultant II	41302	MS-21
Social Service Program Planner I	41311	MS-12
Social Service Program Planner II	41312	MS-16
Social Service Program Planner III	41313	MS-23
Social Service Program Planner IV	41314	MS-28
Social Services Career Trainee	41320	MS-09
Social Worker I	41411	MS-16
Social Worker II	41412	MS-21
Social Worker III	41413	MS-23
Social Worker IV	41414	MS-28
Social Worker Intern	41430	MS-15
Staff Development Specialist I	41771	MS-19
Staff Development Technician I	41781	MS-09
Staff Development Technician II	41782	MS-12
Staff Pharmacist	41787	MS-31
State Mine Inspector	42230	MS-21
State Mine Inspector-At-Large	42240	MS-31
State Police Crime Information Evaluator	41801	MS-08
State Police Evidence Technician I	41901	MS-09
State Police Evidence Technician II	41902	MS-10
State Police Field Specialist I	42001	MS-19
State Police Field Specialist II	42002	MS-23
Statistical Research Specialist I	42741	MS-09
Statistical Research Specialist II	42742	MS-11
Statistical Research Specialist III	42743	MS-16
Statistical Research Supervisor	42745	MS-23
Statistical Research Technician	42748	MS-08
Storage Tank Safety Specialist	43005	MS-19
Storekeeper I	43051	MS-11
Storekeeper II	43052	MS-12
Storekeeper III	43053	MS-13
Stores Clerk	43060	MS-03
Student Intern	43190	MS-01
Student Worker	43200	MS-01
Supervising Vehicle Testing Compliance Officer	43680	MS-22

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Support Service Coordinator I	44221	MS-07
Support Service Coordinator II	44222	MS-09
Support Service Lead	44225	MS-04
Support Service Worker	44238	MS-03
Switchboard Chief Operator	44410	MS-11
Switchboard Operator I	44411	MS-03
Switchboard Operator II	44412	MS-04
Switchboard Operator III	44413	MS-06
Technical Advisor Advanced Program Specialist	45256	MS-31
Technical Advisor I	45251	MS-19
Technical Advisor II	45252	MS-23
Technical Advisor III	45253	MS-29
Technical Manager I	45261	MS-18
Telecommunications Specialist	45295	MS-12
Telecommunications Supervisor	45305	MS-23
Telecommunications Systems Analyst	45308	MS-16
Telecommunications Systems Technician I	45312	MS-07
Telecommunications Systems Technician II	45313	MS-10
Telecommunications Systems Technician Trainee	45314	MS-05
Telecommunicator	45321	MS-09
Telecommunicator − Command Center	45316	MS-10
Telecommunicator Call Taker	45322	MS-11
Telecommunicator Lead Call Taker	45323	MS-14
Telecommunicator Lead Specialist	45327	MS-16
Telecommunicator Lead Worker	45324	MS-11
Telecommunicator Lead Worker − Command Center	45318	MS-12
Telecommunicator Specialist	45326	MS-12
Telecommunicator Trainee	45325	MS-07
Terrorism Research Specialist I	45371	MS-19
Terrorism Research Specialist II	45372	MS-23
Terrorism Research Specialist III	45373	MS-28
Terrorism Research Specialist Trainee	45375	MS-11
Transportation Officer	45830	MS-11
Truck Weighing Inspector	46100	MS-10
Unemployment Insurance Adjudicator I	47001	MS-08
Unemployment Insurance Adjudicator II	47002	MS-10
Unemployment Insurance Adjudicator III	47003	MS-12
Unemployment Insurance Revenue Analyst I	47081	MS-12

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Unemployment Insurance Revenue Analyst II	47082	MS-16
Unemployment Insurance Revenue Specialist	47087	MS-10
Unemployment Insurance Special Agent	47096	MS-19
Utility Engineer I	47451	MS-20
Utility Engineer II	47452	MS-24
Vehicle Compliance Inspector	47570	MS-15
Vehicle Emission Compliance Inspector	47580	MS-10
Vehicle Emission Compliance Supervisor	47583	MS-12
Vehicle Emission Quality Assurance Auditor	47584	MS-10
Vehicle Permit Evaluator	47585	MS-08
Veterans Educational Specialist I	47681	MS-12
Veterans Educational Specialist II	47682	MS-16
Veterans Educational Specialist III	47683	MS-25
Veterans Employment Representative I	47701	MS-11
Veterans Employment Representative II	47702	MS-14
Veterans Nursing Assistant − Certified	47750	MS-05
Veterans Service Officer	47800	MS-11
Veterans Service Officer Associate	47804	MS-10
Veterinarian I	47901	MS-19
Veterinarian II	47902	MS-23
Veterinarian III	47903	MS-25
Veterinary Consumer Safety Officer	47911	MS-20
Veterinary Pathologist	47916	MS-29
Veterinary Supervisor I	47917	MS-25
Veterinary Supervisor II	47918	MS-26
Vision/Hearing Consultant I	47941	MS-14
Vision/Hearing Consultant II	47942	MS-23
Vision/Hearing Consultant III	47943	MS-25
Vital Records Quality Control Inspector	48000	MS-10
Vocational Instructor	48200	MS-09
Volunteer Services Coordinator I	48481	MS-10
Volunteer Services Coordinator II	48482	MS-14
Volunteer Services Coordinator III	48483	MS-19
Wage Claims Specialist	48770	MS-06
Warehouse Claims Specialist	48780	MS-22
Warehouse Examiner	48881	MS-13
Warehouse Examiner Specialist	48882	MS-18
Warehouse Examiner Supervisor	48786	MS-20

Waterways Construction Supervisor I	49061	MS-14
Waterways Construction Supervisor II	49062	MS-19
Weatherization Specialist I	49101	MS-11
Weatherization Specialist II	49102	MS-16
Weatherization Specialist III	49103	MS-23
Weatherization Specialist Trainee	49105	MS-09
Well Inspector I	49421	MS-11
Well Inspector II	49422	MS-18
Workers Compensation Insurance Compliance Investigator	49640	MS-23

NOTE: Effective January 1, 2008, the merit compensation grade 12 in the Personnel Code [20 ILCS 415/8b.18(a) and (b) and 8b.19(a) and (b)] that formerly was indicated by MC-12 is MS-32.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

Section 310.415 Merit Compensation Salary Range Assignments

a) Emergency, Temporary or Provisional Positions – When a position is allocated to a title only assigned to a bargaining unit pay grade and the agency is to appoint an employee to the position on an Emergency (80 Ill. Adm. Code 302.150(b)), Temporary (80 Ill. Adm. Code 302.150(c)) or Provisional (80 Ill. Adm. Code 302.150(d)) basis, a merit compensation salary range to be used for the position shall be assigned to the title as approved by the Director of Central Management Services. The approval of the merit compensation salary range assignment shall be after comparing the highest maximum base salary within the bargaining unit pay grade assigned the title with the maximum base salary in the merit compensation salary range that is not more than the highest maximum base salary within the bargaining unit pay grade and after considering the merit compensation salary ranges assigned to other titles in the same classification series and the merit compensation salary ranges assigned to other titles assigned the same bargaining unit pay grade. The titles and their merit compensation salary range assignments from the previous and anticipated fiscal years shall be listed in the Section 310.410 proposed amendments to the Pay Plan for adoption at the beginning of each fiscal year.

b) Trainee Program Titles – When a classification is established as a Trainee Program (80 Ill. Adm. Code 302.170), the merit compensation salary range assigned to the Trainee Program title shall be approved by the Director of Central Management Services. The approval shall be based on the recommendation of the agency head where the Trainee Program is established, comparison of the salary ranges assigned to other Trainee Program titles, and the maximum base salary in the recommended merit compensation salary range normally being less than the in-hire~~in-hiring~~ rate or the minimum base salary of the targeted classification title for which training is being conducted.

c) Positions excluded from bargaining unit representation by the Illinois Labor Relations Board – When a position is allocated to a title only assigned to a bargaining unit pay grade and the agency or the position is excluded from bargaining unit representation by the Illinois Labor Relations Board, a merit compensation salary range to be used for the position shall be assigned to the title as approved by the Director of Central Management Services. The approval of the merit compensation salary range assignment shall be made using the provisions in subsection (a) if the title is not a Trainee Program title or subsection (b) if the title is a Trainee Program title.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

Section 310.490 Other Pay Provisions

a) Transfer – Upon assignment of an employee to a vacant position in a class with the same salary range as the class for the position being vacated, the employee's base salary will not be changed. Upon separation and subsequent appointment to a position in the same salary range, no increase in salary will be given.

b) Entrance Base Salary –

1) When a candidate only meets the minimum requirements of the class specification upon entry to State service, an employee's entrance base salary is the in-hire~~in-hiring~~ rate or the minimum base salary of the salary range.

2) Qualifications Above Minimum Requirements – If a candidate possesses directly-related education and experience in excess of the minimum

requirements of the class specification, the employing agency may offer the candidate an entrance base salary that is not more than 5% above the candidate's current base salary. Any deviation from the 5% maximum is a special salary adjustment (see Section 310.470).

3) Area Differential – For positions where additional compensation is required because of dissimilar economic or other conditions in the geographical area in which the positions are established, a higher entrance salary may be authorized by the Director of Central Management Services. Present employees receiving less than the new rate of pay shall be advanced to the new rate.

c) Geographical Transfer – Upon geographical transfer from or to an area for which additional compensation has been authorized, an employee will receive an adjustment to the appropriate salary level for the new geographical area of assignment, effective the first day of the month following the date of assignment.

d) Differential and Overtime Pay – An eligible employee may have an amount added to the base salary for a given pay period for work performed in excess of the normal requirements for the position and work schedule, as follows:

1) Shift Differential Pay – An employee may be paid an amount in addition to the base salary for work performed on a regularly scheduled second or third shift. The additional compensation will be at a rate and in a manner approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.

2) Overtime Pay −

A) Eligibility − The Director of Central Management Services shall maintain a listing of classes of positions subject to the provisions of the Merit Compensation System that are eligible for overtime compensation. Classes in salary ranges MS-23 and below are eligible for straight-time overtime unless exceptions are determined by the Director of Central Management Services or

federal guidelines. Employees in these classes of positions who are assigned and perform work in excess of the normal work schedule as established by the agency shall be compensated at a straight-time rate on either a cash or compensatory time-off basis for all hours worked in excess of a normal work week. Overtime in less than one-half hour increments per day shall not be accrued. Classes in MS-24 and above are not eligible for overtime unless required by federal regulation or approved by the Director of Central Management Services. Exceptions must be requested by the employing agency and will be determined on the basis of the special nature of the situation, a substantial need to provide overtime compensation and a significant number of hours worked beyond the normal work schedule, and will be granted only for a specified time period for which the special situation is expected to exist.

B) Compensatory Time − Employees who are eligible for compensatory time may request such time, which may be granted by the agency at its discretion, considering, among other things, its operating needs. Compensatory time shall be taken within the fiscal year it was earned at a time convenient to the employee and consistent with the operating needs of the agency. Compensatory time shall be accrued at the rate in which it is earned (straight time or time and a half), but shall not exceed 120 hours in any fiscal year. Compensatory time approved for non-union employees will be earned after 40 actual work hours in a workweek. Compensatory time not used by the end of the fiscal year in which it was earned shall be liquidated and paid in cash at the rate it was earned. Time spent in travel outside the normal work schedule shall not be accrued as compensatory time except as provided by labor contracts and the Federal Fair Labor Standards Act. At no time are overtime hours or compensatory time to be transferred from one agency to another agency.

e) Equivalent Earned Time –

1) Eligibility – Employees who are non-union or represented by the VR-704 bargaining unit, exempt under the Federal Fair Labor Standards Act, and

in positions not eligible for overtime compensation may receive equivalent earned time for hours worked in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee.

2) Accrual –

A) Employees who are eligible for equivalent earned time shall request that time before working in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee. Requests for equivalent earned time may be granted by the agency at its discretion, considering its operating needs. Equivalent earned time shall be accrued at straight time only to a maximum of 160 hours at any time.

B) Equivalent earned time will accrue in no less than one-quarter hour increments. Time spent in travel outside the normal work schedule shall not be counted toward accrual of equivalent earned time.

3) Compensation – Any approved equivalent earned time shall be taken at a time convenient to the employee and consistent with the operating needs of the agency. The equivalent earned time may be taken in increments of not less than one-quarter hour after a minimum use of one-half hour any time after it is earned. At no time is equivalent earned time to be converted into cash payment or transferred from one agency to another agency.

4) Employees in Positions Represented by an American Federation of State, County and Municipal Employees Bargaining Unit − Employees shall retain their equivalent earned time upon their positions' representation by an American Federation of State, County and Municipal Employees bargaining unit. The use of the equivalent earned time is approved by supervisors, prior to other benefit time excluding sick and personal business leave, in increments of fifteen minutes after the initial use of one-half hour, and granted under the same criteria as vacation time. Employees may substitute equivalent earned time for sick leave in accordance to sick leave policies and procedures.

f) Part-Time Work – Part-time employees whose base salary is other than an hourly or daily basis shall be paid on a daily rate basis computed by dividing the annual rate of salary by the total number of work days in the year.

~~g) Out-of-State Assignment – Employees who are assigned to work out-of-state on a temporary basis may receive an appropriate differential during the period of the assignment, as approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstance.~~

g)~~h)~~ Lump Sum Payment – Lump sum payment shall be provided for accrued vacation, sick leave and unused compensatory overtime at the current base rate to those employees separated from employment under the Personnel Code. Leaves of absence and temporary layoff (per 80 Ill. Adm. Code 302.510) are not separations and therefore lump sum payments cannot be given in these transactions. Methods of computation are explained in Section 310.520(a).

AGENCY NOTE: The method to be used in computing lump sum payment for accrued vacation, sick leave and unused compensatory overtime for an incumbent entitled to shift differential during the regular work hours will be to use the current base salary plus the shift differential pay. Sick leave earned prior to January 1, 1984 and after December 31, 1997 is not compensable. Sick leave earned and not used between January 1, 1984 and December 31, 1997 will be compensable at the current base daily rate times one-half of the total number of compensable sick days.

h)~~i)~~ Salary Treatment upon Return from Leave –

1) An employee returning from Military Leave (80 Ill. Adm. Code 302.220 and 303.170), Peace Corps Leave (80 Ill. Adm. Code 302.230), Service-Connected Disability Leave (80 Ill. Adm. Code 303.135), Educational Leave (80 Ill. Adm. Code 302.215), Disaster Service Leave with Pay (80 Ill. Adm. Code 303.175), Family Responsibility Leave (80 Ill. Adm. Code 303.148), Leave to accept a temporary, emergency, provisional, exempt (80 Ill. Adm. Code 303.155) or trainee position, Leave to serve in

domestic peace or job corps (80 Ill. Adm. Code 302.230) or leave to serve in an interim assignment will have the employee's salary established as determined appropriate by the employing agency and approved by the Director of Central Management Services. However, in no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range. Creditable service date will be maintained.

2) An employee returning to the employee's former salary range from any other leave (not mentioned in subsection (h~~i~~)(1)) of over 14 days will be placed at the salary which the employee received prior to the leave and the creditable service date will be extended by the duration of the leave.

i)~~j)~~ Employees in classes that are made subject to the Merit Compensation System will retain their current salary, except that in no event is the resultant salary to be lower than the minimum rate or higher than the maximum rate of the new salary range.

j)~~k)~~ Temporary Assignment Pay –

1) When Required to Use Second Language Ability – Employees who are bilingual or have the ability to use sign language, Braille, or another second language (e.g., Spanish) and whose job descriptions do not require that they do so shall be paid temporary assignment pay when required to perform duties requiring the ability. The temporary assignment pay received is prorated based on 5% or $100 per month, whichever is greater, in addition to the employee's base rate.

2) When an employee in a position represented by AFSCME (excludes CU-500) – When an employee in a position represented by an AFSCME (excludes CU-500) bargaining unit and allocated to the Public Service Administrator title is temporarily assigned to a non-bargaining unit position, the time frame shall not exceed ~~nine (~~9~~)~~ months, unless mutually agreed otherwise.

k)~~l)~~ Salary Treatment Upon Reemployment –

1) Upon the reemployment of an employee in a class with the same salary

range as the class for the position held before layoff, the employee will be placed at the same salary as held at the time of the layoff, and employee's~~his~~ creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

2) Upon the reemployment of an employee in a class at a lower salary range than the range of the class for the position held before layoff, the employee will be placed at the same salary as held at the time of layoff, except that if this exceeds the maximum of the new range, the employee will be placed at that maximum salary. The creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

l)~~m)~~ Reinstatement – The salary upon reinstatement should not provide more than a 5% increase over the candidate's current base salary or exceed the salary rate held in the position where previously certified without prior approval of the Director of Central Management Services. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range. Any deviation from the 5% maximum, except when the resulting salary is the minimum rate of the salary range, is a special salary adjustment (see Section 310.470).

m)~~n)~~ Bilingual Pay – Individual positions whose job descriptions require the use of sign language, Braille, or another second language (e.g., Spanish) shall receive 5% or $100 per month, whichever is greater, in addition to the employee's base rate.

n)~~o)~~ Clothing or Equipment Allowance – An employee may be paid an amount in addition to the employee's base salary to compensate for clothing or equipment that is required in the performance of assigned duties. The amount will be determined by the Director of the employing agency, and will require approval of the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstance.

o)~~p)~~ Interim Assignment Pay – This subsection of the Pay Plan explains interim assignment pay as applied to certified non-bargaining unit employees in a merit

compensation (including broad-band) position assigned to perform on a full-time interim basis and be accountable for the higher-level duties and responsibilities of the non-bargaining unit (merit compensation, including broad-band) position. On the effective date of the employee's interim assignment (80 Ill. Adm. Code 302.150(j)), the employee shall receive an adjustment as if the employee received a promotion into the higher range. When assigned to the merit compensation position, the adjustment is an amount not more than 5% of the employee's current base salary. In no event is the resulting salary to be lower than the minimum rate or greater than the maximum rate of the salary range to which the employee is being assigned. Upon interim assignment, the employee's creditable service date shall not change. Any deviation from the 5% maximum, except when the resulting salary is the minimum rate of the salary range, is a special salary adjustment (see Section 310.470).

p)~~q)~~ International Differential Pay − For positions with a headquarters outside of the United States, a differential shall be made once a month to the base salary of the employee residing outside the United States to compensate for a change in the currency exchange rate.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

Section 310.495 Broad-Band Pay Range Classes

Broad-band pay range classes shall be covered by all provisions of the Merit Compensation System except for the provisions identified in the following subsections:

a) Salary Range − The salary range for broad-band classes shall be as set out in Appendix G.

b) Entrance Base Salary –

1) When a candidate only meets the minimum requirements of the class specification upon entry to State service, an employee's entrance base salary is the in-hire~~in-hiring~~ rate or the minimum base salary of the salary range.

2) The salary assigned an employee shall take into account the duties, education, training and experience of the employee to assure reasonable

pay equity among employees in the same class.

3) If a candidate possesses directly-related education and experience in excess of the minimum requirements of the class specification, the employing agency may offer the candidate an entrance base salary that is not more than 5% above the candidate's current base salary. Any deviation from the 5% maximum is a special salary adjustment (see Section 310.470).

c) Salary Adjustment for Substantial Additional Duties and Responsibilities within the Same Position or for Transfer to Another Position with Substantial Additional Duties and Responsibilities in the Same Title – An upward salary adjustment that is not more than 5% above the employee's current base salary in a broad-band position classification may be made by the employing agency where the employee's position has been given substantial additional duties and responsibilities but will remain in the same classification or where the employee transfers to another position with substantial additional duties and responsibilities in the same broad-band class. Any deviation from the 5% maximum is a special salary adjustment (see Section 310.470). The salary adjustment shall not change the creditable service date.

d) Movement between Salary Systems − Salary treatment on movement of an employee between one position in the broad-band class series and another position outside of the broad-band class series will be as recommended by the employing agency and approved by the Director of Central Management Services.

e) Salary Treatment upon Initial Placement of Positions in Other Occupational Broad-Band Classes − For the purpose of establishing salary treatment upon initial placement of positions, it is necessary to determine the "lowest corresponding Merit Compensation grade". The Merit Compensation range with a minimum salary closest to, but not lower than, that of the broad-band range minimum is known as the "lowest corresponding Merit Compensation grade".

1) The incumbent of a position with a current salary range maximum equal to or greater than the maximum of the "lowest corresponding Merit Compensation grade" will be placed in the broad-band range with no change in salary.

2) The incumbent of a position with a current salary range maximum less than the maximum of the "lowest corresponding Merit Compensation grade" will be placed in the broad-band range with a 5% increase in current base salary. However, in no event shall the resulting salary be lower than the minimum or higher than the maximum rate of the new salary range. The creditable service date of an employee will not be changed unless an increase of 10% or greater is provided to move the employee to the minimum of the new range.

f) Pay Treatment upon Illinois Labor Relations Board State Panel Revocation of Certification of Representation by a Bargaining Unit – Upon the Illinois Labor Relations Board (ILRB) State Panel issuing a Revocation of Certification of representation by a bargaining unit when an agreement exists between the bargaining unit and the State assigning pay, effective the date of the issuance, the position is subject to the jurisdiction of the Merit Compensation System (Section 310.410) and assigned to the broad-band salary range assigned to the position's classification (Appendix G), and may receive an immediate downward adjustment in base salary (Section 310.480(e)).

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

Section 310.500 Definitions

The following are definitions of certain terms and are for purposes of clarification as they affect the Merit Compensation System only.

"Adjustment in Salary" − A change in salary occasioned by previously committed error or oversight, or required in the best interest of the agency or the state as defined in Sections 310.470 and 310.480.

"Base Salary" − The dollar amount of pay of an employee as determined under the provisions of the Merit Compensation System. Base salary does not include commission, incentive pay, bilingual pay, longevity pay, overtime pay, shift differential pay or deductions for time not worked.

"Bilingual Pay" – The dollar amount per month, or percentage of the employee's monthly base salary, paid in addition to the employee's base salary when the individual position held by the employee has a job description that requires the

use of sign language, Braille, or another second language (e.g., Spanish), or that requires the employee to be bilingual.

"Classification" – The classification established based on the Personnel Code [20 ILCS 415/8a(1)] and to which one or more positions are allocated based upon similarity of duties performed, responsibilities assigned and conditions of employment. Classification may be abbreviated to "class" and referred to by its title or title code.

"Class Specification" – The document comprising the title, title code, effective date, distinguishing features of work, illustrative examples of work and desirable requirements.

"Creditable Service" − All service in full or regularly scheduled part-time pay status beginning with the date of initial employment or the effective date of the last in-range or promotional salary increase. Reevaluations (Sections 310.460(c) and 310.480(d)), reallocations (Sections 310.460(b) and 310.480(b)), adjustments (Sections 310.470, 310.480(e) and 310.495(c)) and interim assignments (Section 310.490(p)) shall not change the creditable service date.

"Comparable Classes" − Two or more classes that are in the same salary range.

"Demotion" − The assignment for cause of an employee to a vacant position in a class in a lower salary range than the former class.

"Differential" − The additional compensation added to the base salary of an employee resulting from conditions of employment imposed during the normal schedule of work.

"Entrance Base Salary" − The initial base salary assigned to an employee upon entering State service.

"In-hire Rate" – An in-hire rate is a minimum rate/step for a class that is above or below the normal minimum of the range or full scale rate, as approved by the Director of Central Management Services after a review of competitive market starting rates for similar classes or as negotiated between the Director of Central Management Services and a bargaining unit.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

"Maximum Rate of Pay" − The highest rate of pay for a given salary range.

"Minimum Rate of Pay" − The lowest rate of pay for a given salary range. Normally the minimum rate of pay represents the salary to be paid a qualified employee who is appointed to a position in a class assigned to a given salary range.

"Option" − The denotation of directly-related education, experience and/or knowledge, skills and abilities required to qualify for the position allocated to the classification. The requirements may meet or exceed the requirements indicated in the classification specification. The following options are for the Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

1	=	General Administration/Business Marketing/Labor/Personnel
2	=	Fiscal Management/Accounting/Budget/Internal Audit/Insurance/Financial
2B	=	Financial Regulatory
2C	=	Economist
3	=	Management Information System/Data Processing/ Telecommunications
3J	=	Java Application Developer
3N	=	Wide Area Networks
4	=	Physical Sciences/Environment
6	=	Health and Human Services
6B	=	Day Care Quality Assurance
6C	=	Health Statistics
6D	=	Health Promotion/Disease Prevention
6E	=	Laboratory Specialist
6F	=	Infectious Disease
6G	=	Disaster/Emergency Medical Services
7	=	Law Enforcement/Correctional
8A	=	Special License − Architect License
8B	=	Special License − Boiler Inspector License
8C	=	Special License − Certified Public Accountant
8D	=	Special License − Federal Communications Commission License/National Association of Business and

		Educational Radio
8E	=	Special License − Engineer (Professional)
8F	=	Special License − Federal Aviation Administration Medical Certificate/First Class
8G	=	Special License − Clinical Professional Counselor
8H	=	Special License − Environmental Health Practitioner
8I	=	Special License − Professional Land Surveyor License
8J	=	Special License − Registered American Dietetic Association/Public Health Food Service Sanitation Certificate/Licensed Dietitian
8K	=	Special License − Licensed Psychologist
8L	=	Special License − Law License
8N	=	Special License − Registered Nurse License
8O	=	Special License − Occupational Therapist License
8P	=	Special License − Pharmacist License
8Q	=	Special License − Religious Ordination by Recognized Commission
8R	=	Special License − Dental Hygienist
8S	=	Special License − Social Worker/Clinical Social Worker
8T	=	Special License − Administrative Certificate issued by the Illinois State Board of Education
8U	=	Special License − Physical Therapist License
8V	=	Special License − Audiologist License
8W	=	Special License − Speech-Language Pathologist License
8X	=	Special License − Blaster Certificate
8Y	=	Special License − Plumbing License
8Z	=	Special License − Special Metrologist Training
9A	=	Special License – Certified Internal Auditor
9B	=	Special License – Certified Information Systems Auditor
9G	=	Special License − Registered Professional Geologist License

The following options are for the Senior Public Service Administrator classification and have a negotiated pay grade and/or a broad-banded salary range assigned:

1	=	General Administration/Business Marketing/Labor/Personnel

2	=	Fiscal Management/Accounting/Budget/ Internal Audit/Insurance/Financial
2B	=	Financial Regulatory
3	=	Management Information System/Data Processing/Telecommunications
4	=	Physical Sciences/Environment
5	=	Agriculture/Conservation
6	=	Health and Human Services
7	=	Law Enforcement/Correctional
8A	=	Special License – Architect License
8B	=	Special License – Boiler Inspector License
8C	=	Special License – Certified Public Accountant/Certified Internal Auditor/Certified Information Systems Auditor
8D	=	Special License – Dental License
8E	=	Special License – Engineer (Professional)
8F	=	Special License – Clinical Professional Counseling
8G	=	Special License – Geologist License
8H	=	Special License – Environmental Health Practitioner
8I	=	Special License – Illinois Auctioneer License
8K	=	Special License – Licensed Psychologist
8L	=	Special License – Law License (Illinois)
8M	=	Special License – Veterinary Medicine License
8N	=	Special License – Nurse (Registered IL) License
8O	=	Special License – Occupational Therapist License
8P	=	Special License – Pharmacist License
8Q	=	Special License – Nursing Home Administration License
8R	=	Special License – Real Estate Brokers License
8S	=	Special License – Social Worker/Clinical Social Worker
8T	=	Special License – Illinois Teaching Certificate (Type 75)/General Administrative Certificate (Type 61) issued by the Illinois State Board of Education
8Z	=	Special License – Certified Real Estate Appraisal License

Other classification titles contain an option and the option also may denote differences in the distinguishing features of work indicated in the classification specification. The classification titles containing an option are:

Children and Family Service Intern, Option 1
Children and Family Service Intern, Option 2
Health Services Investigator I, Option A – General
Health Services Investigator I, Option B − Controlled Substance Inspector
Health Services Investigator II, Option A – General
Health Services Investigator II, Option B − Controlled Substance Inspector
Health Services Investigator II, Option C – Pharmacy
Health Services Investigator II, Option D − Pharmacy/Controlled Substance Inspector
Juvenile Justice Youth and Family Specialist Option 1
Juvenile Justice Youth and Family Specialist Option 2
Medical Administrator I Option C
Medical Administrator I Option D
Medical Administrator II Option C
Medical Administrator II Option D
Physician Specialist − Option A
Physician Specialist − Option B
Physician Specialist − Option C
Physician Specialist − Option D
Physician Specialist − Option E
Research Fellow, Option B

"Performance Review" − The required review of an employee's on-the-job performance as measured by a specific set of criteria.

"Performance Review Date" − The date on which the annual merit increase and bonus shall be made effective if a performance review indicates it is appropriate. Actual performance review procedures are to be completed prior to the effective date of any recommendation to allow sufficient time for the records to be processed by the originating agency.

"Promotion" − The appointment of an employee, with the approval of the agency and the Department of Central Management Services, to a vacant position in a

class in a higher salary range than the former class.

"Reallocation" − The change in the classification of a position resulting from significant changes in assigned duties and responsibilities.

"Reclassification" – The assignment of a position or positions to a different classification based on creation of a new classification or the revision of existing class specification, and approved by the Civil Service Commission.

"Reevaluation" − The assignment of a different salary range to a class of positions based upon a change in relation to other classes or to the labor market.

"Salary Range" − The dollar values encompassed by the minimum and maximum rates of pay of a salary range assigned to a class title.

"Transfer" − The assignment of an employee to a vacant position in a class having the same salary range.

"Work Year" − That period of time determined by the agency and filed with the Department of Central Management Services in accordance with 80 Ill. Adm. Code 303.300.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE E RC-020 (Teamsters Local #330)

~~Full Scale Rates~~

Title	Title Code	Bargaining Unit	Pay Plan Code	Full Scale Mo.	Effective Date
Highway Maintainer (Snowbirds)	18639	RC-020	Q	3664.00	January 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-020	Q	3738.00	July 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-020	Q	3850.00	January 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-020	Q	3964.00	July 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-020	Q	4083.00	January 1, 2012
Highway Maintainer (Snowbirds)	18639	RC-020	Q	4205.00	June 30, 2012

NOTE: Snowbirds are all, except those in Kankakee County, seasonal, full-time Highway Maintainers whose primary function is snow removal.

Effective July 1, 2012

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic	05310	Q											5990	34.43
Bridge Tender	05320	B											5663	32.55
Heavy Construction Equipment Operator	18465	Q											6073	34.90
Heavy Construction Equipment Operator (Bridge Crew)	18465	Q											6160	35.40
Highway Maintainer	18639	Q	4529	26.03	4830	27.76	5132	29.49	5434	31.23	5736	32.97	5947	34.18

Highway Maintainer (Bridge Crew)	18639	Q	4555	26.18	4858	27.92	5162	29.67	5466	31.41	5769	33.16	6038	34.70
Highway Maintainer (Drill Rig)	18639	Q	4460	25.63	4758	27.34	5055	29.05	5352	30.76	5650	32.47	6073	34.90
Highway Maintenance Lead Worker	18659	Q											6112	35.13
Highway Maintenance Lead Worker (Bridge Crew)	18659	Q											6199	35.63
Highway Maintenance Lead Worker (Lead Lead Worker)	18659	Q											6174	35.48
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)	18659	Q											6261	35.98
Labor Maintenance Lead Worker	22809	B											5827	33.49
Laborer (Maintenance)	23080	B											5757	33.09
Maintenance Equipment Operator	25020	B											5873	33.75
Maintenance Equipment Operator	25020	Q											6073	34.90
Maintenance Worker (DHS)	25500	B											5879	33.79
Maintenance Worker (DOT, not Emergency Patrol)	25500	B											5804	33.36
Power Shovel Operator (Maintenance)	33360	Q											6073	34.90
Power Shovel Operator	33360	Q											6160	35.40

(Maintenance) (Bridge Crew)														
Silk Screen Operator	41020	B											5999	34.48

Effective June 26, 2013

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic	05310	Q	4493	25.82	4792	27.54	5092	29.26	5391	30.98	5691	32.71	5990	34.43
Bridge Tender	05320	B	4247	24.41	4530	26.03	4814	27.67	5097	29.29	5380	30.92	5663	32.55
Heavy Construction Equipment Operator	18465	Q	4555	26.18	4858	27.92	5162	29.67	5466	31.41	5769	33.16	6073	34.90
Heavy Construction Equipment Operator (Bridge Crew)	18465	Q	4620	26.55	4928	28.32	5236	30.09	5544	31.86	5852	33.63	6160	35.40
Highway Maintainer	18639	Q	4529	26.03	4830	27.76	5132	29.49	5434	31.23	5736	32.97	5947	34.18
Highway Maintainer (Bridge Crew)	18639	Q	4555	26.18	4858	27.92	5162	29.67	5466	31.41	5769	33.16	6038	34.70
Highway Maintainer (Drill Rig)	18639	Q	4460	25.63	4758	27.34	5055	29.05	5352	30.76	5650	32.47	6073	34.90
Highway Maintenance Lead Worker	18659	Q	4584	26.34	4890	28.10	5195	29.86	5501	31.61	5806	33.37	6112	35.13
Highway Maintenance Lead Worker (Bridge Crew)	18659	Q	4649	26.72	4959	28.50	5269	30.28	5579	32.06	5889	33.84	6199	35.63
Highway Maintenance Lead Worker (Lead Lead Worker)	18659	Q	4631	26.61	4939	28.39	5248	30.16	5557	31.94	5865	33.71	6174	35.48

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)	18659	Q	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Labor Maintenance Lead Worker	22809	B	4370	25.11	4662	26.79	4953	28.47	5244	30.14	5536	31.82	5827	33.49
Laborer (Maintenance)	23080	B	4318	24.82	4606	26.47	4893	28.12	5181	29.78	5469	31.43	5757	33.09
Maintenance Equipment Operator	25020	B	4405	25.32	4698	27.00	4992	28.69	5286	30.38	5579	32.06	5873	33.75
Maintenance Equipment Operator	25020	Q	4555	26.18	4858	27.92	5162	29.67	5466	31.41	5769	33.16	6073	34.90
Maintenance Worker (DHS)	25500	B	4409	25.34	4703	27.03	4997	28.72	5291	30.41	5585	32.10	5879	33.79
Maintenance Worker (DOT, not Emergency Patrol)	25500	B	4353	25.02	4643	26.68	4933	28.35	5224	30.02	5514	31.69	5804	33.36
Power Shovel Operator (Maintenance)	33360	Q	4555	26.18	4858	27.92	5162	29.67	5466	31.41	5769	33.16	6073	34.90
Power Shovel Operator (Maintenance) (Bridge Crew)	33360	Q	4620	26.55	4928	28.32	5236	30.09	5544	31.86	5852	33.63	6160	35.40
Silk Screen Operator	41020	B	4499	25.86	4799	27.58	5099	29.30	5399	31.03	5699	32.75	5999	34.48

Effective July 1, 2013

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic	05310	Q	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11
Bridge Tender	05320	B	4332	24.90	4621	26.56	4910	28.22	5198	29.87	5487	31.53	5776	33.20

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Heavy Construction Equipment Operator	18465	Q	4712	27.08	5026	28.89	5341	30.70	5655	32.50	5969	34.30	6194	35.60
Heavy Construction Equipment Operator (Bridge Crew)	18465	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6283	36.11
Highway Maintainer	18639	Q	4619	26.55	4927	28.32	5235	30.09	5543	31.86	5851	33.63	6066	34.86
Highway Maintainer (Bridge Crew)	18639	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6159	35.40
Highway Maintainer (Drill Rig)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6194	35.60
Highway Maintenance Lead Worker	18659	Q	4790	27.53	5109	29.36	5428	31.20	5747	33.03	6067	34.87	6234	35.83
Highway Maintenance Lead Worker (Bridge Crew)	18659	Q	4723	27.14	5038	28.95	5352	30.76	5667	32.57	5982	34.38	6323	36.34
Highway Maintenance Lead Worker (Lead Lead Worker)	18659	Q	4742	27.25	5058	29.07	5375	30.89	5691	32.71	6007	34.52	6297	36.19
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)	18659	Q	4676	26.87	4987	28.66	5299	30.45	5611	32.25	5922	34.03	6386	36.70
Labor Maintenance Lead Worker	22809	B	4458	25.62	4755	27.33	5052	29.03	5350	30.75	5647	32.45	5944	34.16
Laborer (Maintenance)	23080	B	4404	25.31	4698	27.00	4991	28.68	5285	30.37	5578	32.06	5872	33.75
Maintenance Equipment Operator	25020	B	4493	25.82	4792	27.54	5092	29.26	5391	30.98	5691	32.71	5990	34.43

Maintenance Equipment Operator	25020	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6194	35.60
Maintenance Worker (DHS)	25500	B	4440	25.52	4736	27.22	5032	28.92	5328	30.62	5624	32.32	5997	34.47
Maintenance Worker (DOT, not Emergency Patrol)	25500	B	4498	25.85	4798	27.57	5097	29.29	5397	31.02	5697	32.74	5920	34.02
Power Shovel Operator (Maintenance)	33360	Q	4712	27.08	5026	28.89	5341	30.70	5655	32.50	5969	34.30	6194	35.60
Power Shovel Operator (Maintenance) (Bridge Crew)	33360	Q	4646	26.70	4955	28.48	5265	30.26	5575	32.04	5884	33.82	6283	36.11
Silk Screen Operator	41020	B	4589	26.37	4895	28.13	5201	29.89	5507	31.65	5813	33.41	6119	35.17

Effective July 1, 2014

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic	05310	Q	4674	26.86	4986	28.66	5297	30.44	5609	32.24	5920	34.02	6232	35.82
Bridge Tender	05320	B	4419	25.40	4714	27.09	5008	28.78	5303	30.48	5597	32.17	5892	33.86
Heavy Construction Equipment Operator	18465	Q	4807	27.63	5127	29.47	5448	31.31	5768	33.15	6089	34.99	6318	36.31
Heavy Construction Equipment Operator (Bridge Crew)	18465	Q	4739	27.24	5054	29.05	5370	30.86	5686	32.68	6002	34.49	6409	36.83
Highway Maintainer	18639	Q	4712	27.08	5026	28.89	5340	30.69	5654	32.49	5968	34.30	6187	35.56
Highway Maintainer (Bridge Crew)	18639	Q	4739	27.24	5054	29.05	5370	30.86	5686	32.68	6002	34.49	6282	36.10
Highway Maintainer (Drill Rig)	18639	Q	4640	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6318	36.31

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker	18659	Q	4886	28.08	5211	29.95	5537	31.82	5863	33.70	6188	35.56	6359	36.55
Highway Maintenance Lead Worker (Bridge Crew)	18659	Q	4817	27.68	5138	29.53	5460	31.38	5781	33.22	6102	35.07	6449	37.06
Highway Maintenance Lead Worker (Lead Lead Worker)	18659	Q	4837	27.80	5159	29.65	5482	31.51	5804	33.36	6127	35.21	6423	36.91
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)	18659	Q	4769	27.41	5087	29.24	5405	31.06	5723	32.89	6041	34.72	6514	37.44
Labor Maintenance Lead Worker	22809	B	4547	26.13	4850	27.87	5154	29.62	5457	31.36	5760	33.10	6063	34.84
Laborer (Maintenance)	23080	B	4492	25.82	4791	27.53	5091	29.26	5390	30.98	5690	32.70	5989	34.42
Maintenance Equipment Operator	25020	B	4583	26.34	4888	28.09	5194	29.85	5499	31.60	5805	33.36	6110	35.11
Maintenance Equipment Operator	25020	Q	4739	27.24	5054	29.05	5370	30.86	5686	32.68	6002	34.49	6318	36.31
Maintenance Worker (DHS)	25500	B	4529	26.03	4830	27.76	5132	29.49	5434	31.23	5736	32.97	6117	35.16
Maintenance Worker (DOT, not Emergency Patrol)	25500	B	4588	26.37	4894	28.13	5199	29.88	5505	31.64	5811	33.40	6038	34.70
Power Shovel Operator (Maintenance)	33360	Q	4807	27.63	5127	29.47	5448	31.31	5768	33.15	6089	34.99	6318	36.31
Power Shovel Operator (Maintenance) (Bridge Crew)	33360	Q	4739	27.24	5054	29.05	5370	30.86	5686	32.68	6002	34.49	6409	36.83
Silk Screen Operator	41020	B	4681	26.90	4993	28.70	5305	30.49	5617	32.28	5929	34.07	6241	35.87

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

~~Title~~	~~Title Code~~	~~Bargaining Unit~~	~~Pay Plan Code~~	~~July 1, 2012~~		~~July 1, 2013~~		~~July 1, 2014~~	
				~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~
~~Bridge Mechanic~~	~~05310~~	~~RC-020~~	~~Q~~	~~5990~~	~~34.43~~	~~6110~~	~~35.11~~	~~6232~~	~~35.82~~
~~Bridge Tender~~	~~05320~~	~~RC-020~~	~~B~~	~~5663~~	~~32.55~~	~~5776~~	~~33.20~~	~~5892~~	~~33.86~~
~~Heavy Construction Equipment Operator~~	~~18465~~	~~RC-020~~	~~Q~~	~~6073~~	~~34.90~~	~~6194~~	~~35.60~~	~~6318~~	~~36.31~~
~~Heavy Construction Equipment Operator (Bridge Crew)~~	~~18465~~	~~RC-020~~	~~Q~~	~~6160~~	~~35.40~~	~~6283~~	~~36.11~~	~~6409~~	~~36.83~~
~~Highway Maintainer~~	~~18639~~	~~RC-020~~	~~Q~~	~~5947~~	~~34.18~~	~~6066~~	~~34.86~~	~~6187~~	~~35.56~~
~~Highway Maintainer (Bridge Crew)~~	~~18639~~	~~RC-020~~	~~Q~~	~~6038~~	~~34.70~~	~~6159~~	~~35.40~~	~~6282~~	~~36.10~~
~~Highway Maintainer (Drill Rig)~~	~~18639~~	~~RC-020~~	~~Q~~	~~6073~~	~~34.90~~	~~6194~~	~~35.60~~	~~6318~~	~~36.31~~
~~Highway Maintenance Lead Worker~~	~~18659~~	~~RC-020~~	~~Q~~	~~6112~~	~~35.13~~	~~6234~~	~~35.83~~	~~6359~~	~~36.55~~
~~Highway Maintenance Lead Worker (Bridge Crew)~~	~~18659~~	~~RC-020~~	~~Q~~	~~6199~~	~~35.63~~	~~6323~~	~~36.34~~	~~6449~~	~~37.06~~
~~Highway Maintenance Lead Worker (Lead Lead Worker)~~	~~18659~~	~~RC-020~~	~~Q~~	~~6174~~	~~35.48~~	~~6297~~	~~36.19~~	~~6423~~	~~36.91~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)~~	~~18659~~	~~RC-020~~	~~Q~~	~~6261~~	~~35.98~~	~~6386~~	~~36.70~~	~~6514~~	~~37.44~~
~~Labor Maintenance Lead Worker~~	~~22809~~	~~RC-020~~	~~B~~	~~5827~~	~~33.49~~	~~5944~~	~~34.16~~	~~6063~~	~~34.84~~
~~Laborer (Maintenance)~~	~~23080~~	~~RC-020~~	~~B~~	~~5757~~	~~33.09~~	~~5872~~	~~33.75~~	~~5989~~	~~34.42~~
~~Maintenance Equipment Operator~~	~~25020~~	~~RC-020~~	~~B~~	~~5873~~	~~33.75~~	~~5990~~	~~34.43~~	~~6110~~	~~35.11~~
~~Maintenance Equipment Operator~~	~~25020~~	~~RC-020~~	~~Q~~	~~6073~~	~~34.90~~	~~6194~~	~~35.60~~	~~6318~~	~~36.31~~
~~Maintenance Worker (DHS)~~	~~25500~~	~~RC-020~~	~~B~~	~~5879~~	~~33.79~~	~~5997~~	~~34.47~~	~~6117~~	~~35.16~~
~~Maintenance Worker (DOT, not Emergency Patrol)~~	~~25500~~	~~RC-020~~	~~B~~	~~5804~~	~~33.36~~	~~5920~~	~~34.02~~	~~6038~~	~~34.70~~
~~Power Shovel Operator (Maintenance)~~	~~33360~~	~~RC-020~~	~~Q~~	~~6073~~	~~34.90~~	~~6194~~	~~35.60~~	~~6318~~	~~36.31~~
~~Power Shovel Operator (Maintenance) (Bridge Crew)~~	~~33360~~	~~RC-020~~	~~Q~~	~~6160~~	~~35.40~~	~~6283~~	~~36.11~~	~~6409~~	~~36.83~~
~~Silk Screen Operator~~	~~41020~~	~~RC-020~~	~~B~~	~~5999~~	~~34.48~~	~~6119~~	~~35.17~~	~~6241~~	~~35.87~~

~~New Hire Rates~~

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Title	Pay Plan Code	New Hire Between the Dates	July 1, 2013 Mo.	July 1, 2013 Hr.	July 1, 2014 Mo.	July 1, 2014 Hr.	On employee's "new hire" anniversary July 2014-June 2015 Mo.	On employee's "new hire" anniversary July 2014-June 2015 Hr.
Bridge Mechanic	Q	(7/1/13-6/30/14)	4583	26.34	4674	26.86	4986	28.66
Bridge Mechanic	Q	(7/1/14-6/30/15)			4674	26.86		
Bridge Tender	B	(7/1/13-6/30/14)	4332	24.90	4419	25.40	4714	27.09
Bridge Tender	B	(7/1/14-6/30/15)			4419	25.40		
Heavy Construction Equipment Operator	Q	(7/1/13-6/30/14)	4646	26.70	4739	27.24	5054	29.05
Heavy Construction Equipment Operator	Q	(7/1/14-6/30/15)			4739	27.24		
Heavy Construction Equipment Operator (Bridge Crew)	Q	(7/1/13-6/30/14)	4712	27.08	4807	27.63	5127	29.47
Heavy Construction Equipment Operator (Bridge Crew)	Q	(7/1/14-6/30/15)			4807	27.63		
Highway Maintainer	Q							

New Hire Between the Dates	July 1, 2013 Mo.	July 1, 2013 Hr.	On employee's "new hire" anniversary July 2013-June 2014 Mo.	On employee's "new hire" anniversary July 2013-June 2014 Hr.	July 1, 2014 Mo.	July 1, 2014 Hr.	On employee's "new hire" anniversary July 2014-June 2015 Mo.	On employee's "new hire" anniversary July 2014-June 2015 Hr.
(7/1/09-10/31/09)	5763	33.12	Full Scale Rate		Full Scale Rate		Full Scale Rate	
(11/1/09-12/31/09)	5459	31.37	5763	33.12	5878	33.78	Full Scale Rate	
(1/1/10-6/30/10)	5459	31.37	5763	33.12	5878	33.78	Full Scale Rate	
(7/1/10-12/31/10)	5156	29.63	5459	31.37	5568	32.00	5878	33.78
(1/1/11-6/30/11)	5156	29.63	5459	31.37	5568	32.00	5878	33.78
(7/1/11-12/31/11)	4853	27.89	5156	29.63	5259	30.22	5568	32.00
(1/1/12-6/30/12)	4853	27.89	5156	29.63	5259	30.22	5568	32.00
(7/1/12-12/31/12)	4550	26.15	4853	27.89	4950	28.45	5259	30.22
(1/1/13-6/30/13)	4550	26.15	4853	27.89	4950	28.45	5259	30.22
(7/1/13-6/30/14)	4550	26.15			4640	26.67	4950	28.45
(7/1/14-6/30/15)					4640	26.67		

Title

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

	Pay Plan Code
Highway Maintainer (Bridge Crew)	Q

New Hire Between the Dates	July 1, 2013		On employee's "new hire" anniversary July 2013-June 2014		July 1, 2014		On employee's "new hire" anniversary July 2014-June 2015	
	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
(7/1/09-10/31/09)	5851	33.63	Full Scale Rate		Full Scale Rate		Full Scale Rate	
(11/1/09-12/31/09)	5543	31.86	5851	33.63	5968	34.30	Full Scale Rate	
(1/1/10-6/30/10)	5543	31.86	5851	33.63	5968	34.30	Full Scale Rate	
(7/1/10-12/31/10)	5235	30.09	5543	31.86	5654	32.49	5968	34.30
(1/1/11-6/30/11)	5235	30.09	5543	31.86	5654	32.49	5968	34.30
(7/1/11-12/31/11)	4927	28.32	5235	30.09	5340	30.69	5654	32.49
(1/1/12-6/30/12)	4927	28.32	5235	30.09	5340	30.69	5654	32.49
(7/1/12-12/31/12)	4619	26.55	4927	28.32	5026	28.89	5340	30.69
(1/1/13-6/30/13)	4619	26.55	4927	28.32	5026	28.89	5340	30.69
(7/1/13-6/30/14)	4619	26.55			4712	27.08	5026	28.89
(7/1/14-6/30/15)					4712	27.08		

Title	Pay Plan Code
Highway Maintainer (Drill Rig)	Q

New Hire Between the Dates	July 1, 2013		On employee's "new hire" anniversary July 2013-June 2014		July 1, 2014		On employee's "new hire" anniversary July 2014-June 2015	
	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
(7/1/09-10/31/09)	5884	33.82	Full Scale Rate		Full Scale Rate		Full Scale Rate	
(11/1/09-12/31/09)	5575	32.04	5884	33.82	6002	34.49	Full Scale Rate	
(1/1/10-6/30/10)	5575	32.04	5884	33.82	6002	34.49	Full Scale Rate	
(7/1/10-12/31/10)	5265	30.26	5575	32.04	5686	32.68	6002	34.49
(1/1/11-6/30/11)	5265	30.26	5575	32.04	5686	32.68	6002	34.49
(7/1/11-12/31/11)	4955	28.48	5265	30.26	5370	30.86	5686	32.68

~~(1/1/12-6/30/12)~~	~~4955~~	~~28.48~~	~~5265~~	~~30.26~~	~~5370~~	~~30.86~~	~~5686~~	~~32.68~~
~~(7/1/12-12/31/12)~~	~~4646~~	~~26.70~~	~~4955~~	~~28.48~~	~~5054~~	~~29.05~~	~~5370~~	~~30.86~~
~~(1/1/13-6/30/13)~~	~~4646~~	~~26.70~~	~~4955~~	~~28.48~~	~~5054~~	~~29.05~~	~~5370~~	~~30.86~~
~~(7/1/13-6/30/14)~~	~~4646~~	~~26.70~~			~~4739~~	~~27.24~~	~~5054~~	~~29.05~~
~~(7/1/14-6/30/15)~~					~~4739~~	~~27.24~~		

~~**Title**~~	~~**Pay Plan Code**~~	~~**New Hire Between the Dates**~~	~~**July 1, 2013**~~		~~**July 1, 2014**~~		~~**On employee's "new hire" anniversary July 2014-June 2015**~~	
			~~**Mo.**~~	~~**Hr.**~~	~~**Mo.**~~	~~**Hr.**~~	~~**Mo.**~~	~~**Hr.**~~
~~Highway Maintenance Lead Worker~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4676~~	~~26.87~~	~~4769~~	~~27.41~~	~~5087~~	~~29.24~~
~~Highway Maintenance Lead Worker~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4769~~	~~27.41~~		
~~Highway Maintenance Lead Worker (Bridge Crew)~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4742~~	~~27.25~~	~~4837~~	~~27.80~~	~~5159~~	~~29.65~~
~~Highway Maintenance Lead Worker (Bridge Crew)~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4837~~	~~27.80~~		
~~Highway Maintenance Lead Worker (Lead Lead Worker)~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4723~~	~~27.14~~	~~4817~~	~~27.68~~	~~5138~~	~~29.53~~
~~Highway Maintenance Lead Worker (Lead Lead Worker)~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4817~~	~~27.68~~		
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4790~~	~~27.53~~	~~4886~~	~~28.08~~	~~5211~~	~~29.95~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew)~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4886~~	~~28.08~~		
~~Labor Maintenance Lead Worker~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4458~~	~~25.62~~	~~4547~~	~~26.13~~	~~4850~~	~~27.87~~
~~Labor Maintenance Lead Worker~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4547~~	~~26.13~~		
~~Laborer (Maintenance)~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4404~~	~~25.31~~	~~4492~~	~~25.82~~	~~4791~~	~~27.53~~
~~Laborer (Maintenance)~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4492~~	~~25.82~~		

~~Maintenance Equipment Operator~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4493~~	~~25.82~~	~~4583~~	~~26.34~~	~~4888~~	~~28.09~~
~~Maintenance Equipment Operator~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4583~~	~~26.34~~		
~~Maintenance Equipment Operator~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4646~~	~~26.70~~	~~4739~~	~~27.24~~	~~5054~~	~~29.05~~
~~Maintenance Equipment Operator~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4739~~	~~27.24~~		
~~Maintenance Worker (DHS)~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4498~~	~~25.85~~	~~4588~~	~~26.37~~	~~4894~~	~~28.13~~
~~Maintenance Worker (DHS)~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4588~~	~~26.37~~		
~~Maintenance Worker (DOT, not Emergency Patrol)~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4440~~	~~25.52~~	~~4529~~	~~26.03~~	~~4830~~	~~27.76~~
~~Maintenance Worker (DOT, not Emergency Patrol)~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4529~~	~~26.03~~		
~~Power Shovel Operator (Maintenance)~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4646~~	~~26.70~~	~~4739~~	~~27.24~~	~~5054~~	~~29.05~~
~~Power Shovel Operator (Maintenance)~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4739~~	~~27.24~~		
~~Power Shovel Operator (Maintenance) (Bridge Crew)~~	~~Q~~	~~(7/1/13-6/30/14)~~	~~4712~~	~~27.08~~	~~4807~~	~~27.63~~	~~5127~~	~~29.47~~
~~Power Shovel Operator (Maintenance) (Bridge Crew)~~	~~Q~~	~~(7/1/14-6/30/15)~~			~~4807~~	~~27.63~~		
~~Silk Screen Operator~~	~~B~~	~~(7/1/13-6/30/14)~~	~~4589~~	~~26.37~~	~~4681~~	~~26.90~~	~~4993~~	~~28.70~~
~~Silk Screen Operator~~	~~B~~	~~(7/1/14-6/30/15)~~			~~4681~~	~~26.90~~		

NOTE

~~Note~~: Effective July 1, 2011, the clothing allowance for Heavy Construction Equipment Operators, Highway Maintainers, Highway Maintenance Lead Workers, Highway Maintenance Lead Lead Workers, Silk Screen Operators, and Bridge Mechanics employees increases to $200. Effective July 1, 2011, the clothing allowance for all other titles increases to $100. The allowance shall be applied only to certified employees who are on the active payroll effective July 1. Employees on authorized leave of absence on July 1 shall be paid the allowance on a prorated basis upon return from leave.

Employees covered by this bargaining unit shall receive a one-time 2.25% stipend based on the employee's~~Employee's~~ base salary effective June 1, 2013. The~~Such~~ stipend will not be added to the employee's~~Employee's~~ base salary. Permanent part-time employees will be paid on a prorated~~pro-rated~~ stipend based upon their regular work schedule, which will not be added into the base salary. To be eligible for this stipend, an employee must be on the payroll effective June 1, 2013~~213~~. Employees on a leave of absence who would otherwise be eligible to receive the fiscal year 2013 lump sum stipend shall receive that~~such~~ stipend upon their return to active payroll, as long as they return during ~~the~~ fiscal year 2013. An employee~~,~~ who worked during fiscal year 2013~~, which dates are~~ (July 1, 2012 through June 30, 2013)~~,~~ and was~~were~~ on an authorized Worker's Compensation Leave of Absence, shall be paid the fiscal year 2013 stipend upon the employee's~~their~~ official return to work sometime during fiscal year 2014, unless otherwise compensated for the stipend. Return to work is defined as the employee's first day back to active payroll status with an authorized licensed physician's release.

New hire rates for the Highway Maintainer title from the 2008-2012 Collective Bargaining Agreement shall continue in effect at~~as was amended to~~ 75%. All classifications~~classification~~ shall have a 75% new hire rate for all employees hired on or after July 1, 2013. Employees who are promoted and are in the new hire progression will promote to the next step of the new hire rate of the higher classification. In addition, temporary assignments shall also be calculated at the new hire rates. Employees in the new hire rates will receive a 5% increase each year for five years on their anniversary date in order to obtain the full rate. All full scale employees will be promoted to full scale ~~full-scale~~ rate of the next higher classification.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE F RC-019 (Teamsters Local #25)

~~Full Scale Rates~~

Title	Title Code	Bargaining Unit	Pay Plan Code	Full Scale Mo.	Effective Date
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3664.00	January 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3738.00	July 1, 2010
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3850.00	January 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-019	Q	3964.00	July 1, 2011
Highway Maintainer (Snowbirds)	18639	RC-019	Q	4083.00	January 1, 2012
Highway Maintainer (Snowbirds)	18639	RC-019	Q	4205.00	June 30, 2012

NOTE: Snowbirds are all seasonal, salaried, full-time Highway Maintainers whose primary function is snow removal.

Effective July 1, 2012

Title	Title Code	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic (IDOT)	05310	Q											5982	34.38
Bridge Tender (IDOT)	05320	B											6018	34.59
Deck Hand (IDOT)	11500	B											5782	33.23
Ferry Operator I (IDOT)	14801	B											6018	34.59
Ferry Operator II (IDOT)	14802	B											6070	34.89
Highway Maintainer (Regular - RG) (IDOT)	18639	Q	4460	25.63	4758	27.34	5055	29.05	5352	30.76	5650	32.47	5947	34.18

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintainer (Bridge Crew - BC) (IDOT)	18639	Q	4517	25.96	4818	27.69	5119	29.42	5420	31.15	5721	32.88	6022	34.61
Highway Maintainer (Drill Rig - DR) (IDOT)	18639	Q	4539	26.09	4842	27.83	5144	29.56	5447	31.30	5749	33.04	6052	34.78
Highway Maintainer (Emergency Patrol - EP) (IDOT)	18639	Q	4541	26.10	4843	27.83	5146	29.57	5449	31.32	5751	33.05	6054	34.79
Highway Maintenance Lead Worker (Regular - RG) (IDOT)	18659	Q											6085	34.97
Highway Maintenance Lead Worker (Bridge Crew - BC) (IDOT)	18659	Q											6159	35.40
Highway Maintenance Lead Worker (Emergency Patrol - EP) (IDOT)	18659	Q											6192	35.59
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular - RG) (IDOT)	18659	Q											6138	35.28
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew - BC) (IDOT)	18659	Q											6212	35.70

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol - EP) (IDOT)	18659	Q	6217	35.73
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	5574	32.03
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	5607	32.22
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	5844	33.59
Laborer (Maintenance) (IDOT)	23080	B	5785	33.25
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	5882	33.80
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	6052	34.78
Maintenance Equipment	25020	S	6105	35.09

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Operator (DOC - Maximum Security)					
Maintenance Equipment Operator (DHS - Forensics)	25020	Q		5947	34.18
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B		5823	33.47
Maintenance Worker (DHS - Forensics)	25500	Q		5888	33.84
Power Shovel Operator (Maintenance) (Regular - RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B		5986	34.40
Power Shovel Operator (Maintenance) (Regular - RG) (IDOT)	33360	Q		6052	34.78
Power Shovel Operator (Maintenance) (Bridge Crew - BC) (IDOT)	33360	Q		6127	35.21
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B		5603	32.20
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B		5653	32.49

Silk Screen Operator (IDOT)	41020	B											5991	34.43

Effective July 1, 2013

Title	Title	Pay Plan Code	75% Mo.	75% Hr.	80% Mo.	80% Hr.	85% Mo.	85% Hr.	90% Mo.	90% Hr.	95% Mo.	95% Hr.	Full Scale Mo.	Full Scale Hr.
Bridge Mechanic (IDOT)	05310	Q											6102	35.07
Bridge Tender (IDOT)	05320	B											6138	35.28
Deck Hand (IDOT)	11500	B											5898	33.90
Ferry Operator I (IDOT)	14801	B											6138	35.28
Ferry Operator II (IDOT)	14802	B											6191	35.58
Highway Maintainer (Regular - RG) (IDOT)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86
Highway Maintainer (Bridge Crew - BC) (IDOT)	18639	Q	4607	26.48	4914	28.24	5221	30.01	5528	31.77	5835	33.53	6142	35.30
Highway Maintainer (Drill Rig - DR) (IDOT)	18639	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Highway Maintainer (Emergency Patrol - EP) (IDOT)	18639	Q											6175	35.49
Highway Maintenance Lead Worker (Regular - RG) (IDOT)	18659	Q											6207	35.67
Highway Maintenance Lead Worker	18659	Q											6282	36.10

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Bridge Crew - BC) (IDOT)				
Highway Maintenance Lead Worker (Emergency Patrol - EP) (IDOT)	18659	Q	6316	36.30
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular - RG) (IDOT)	18659	Q	6261	35.98
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew - BC) (IDOT)	18659	Q	6336	36.41
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol - EP) (IDOT)	18659	Q	6341	36.44
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	5685	32.67
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	5719	32.87

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	5961	34.26
Laborer (Maintenance) (IDOT)	23080	B	5901	33.91
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	6000	34.48
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	6173	35.48
Maintenance Equipment Operator (DOC - Maximum Security)	25020	S	6227	35.79
Maintenance Equipment Operator (DHS - Forensics)	25020	Q	6066	34.86
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	5939	34.13
Maintenance Worker (DHS - Forensics)	25500	Q	6006	34.52
Power Shovel Operator (Maintenance) (Regular - RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	6106	35.09

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Power Shovel Operator (Maintenance) (Regular - RG) (IDOT)	33360	Q	6173	35.48
Power Shovel Operator (Maintenance) (Bridge Crew - BC) (IDOT)	33360	Q	6250	35.92
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	5715	32.84
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	5766	33.14
Silk Screen Operator (IDOT)	41020	B	6111	35.12

Effective July 8, 2013

Title	Title	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic (IDOT)	05310	Q	4577	26.30	4882	28.06	5187	29.81	5492	31.56	5797	33.32	6102	35.07
Bridge Tender (IDOT)	05320	B	4604	26.46	4910	28.22	5217	29.98	5524	31.75	5831	33.51	6138	35.28
Deck Hand (IDOT)	11500	B	4424	25.43	4718	27.11	5013	28.81	5308	30.51	5603	32.20	5898	33.90
Ferry Operator I (IDOT)	14801	B	4604	26.46	4910	28.22	5217	29.98	5524	31.75	5831	33.51	6138	35.28
Ferry Operator II (IDOT)	14802	B	4643	26.68	4953	28.47	5262	30.24	5572	32.02	5881	33.80	6191	35.58
Highway Maintainer (Regular - RG) (IDOT)	18639	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6066	34.86

Highway Maintainer (Bridge Crew - BC) (IDOT)	18639	Q	4607	26.48	4914	28.24	5221	30.01	5528	31.77	5835	33.53	6142	35.30
Highway Maintainer (Drill Rig - DR) (IDOT)	18639	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Highway Maintainer (Emergency Patrol - EP) (IDOT)	18639	Q	4631	26.61	4940	28.39	5249	30.17	5558	31.94	5866	33.71	6175	35.49
Highway Maintenance Lead Worker (Regular - RG) (IDOT)	18659	Q	4655	26.75	4966	28.54	5276	30.32	5586	32.10	5897	33.89	6207	35.67
Highway Maintenance Lead Worker (Bridge Crew - BC) (IDOT)	18659	Q	4712	27.08	5026	28.89	5340	30.69	5654	32.49	5968	34.30	6282	36.10
Highway Maintenance Lead Worker (Emergency Patrol - EP) (IDOT)	18659	Q	4737	27.22	5053	29.04	5369	30.86	5684	32.67	6000	34.48	6316	36.30
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular - RG) (IDOT)	18659	Q	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew - BC) (IDOT)	18659	Q	4752	27.31	5069	29.13	5386	30.95	5702	32.77	6019	34.59	6336	36.41

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol - EP) (IDOT)	18659	Q	4756	27.33	5073	29.16	5390	30.98	5707	32.80	6024	34.62	6341	36.44
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	4264	24.51	4548	26.14	4832	27.77	5117	29.41	5401	31.04	5685	32.67
Janitor II (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21952	B	4289	24.65	4575	26.29	4861	27.94	5147	29.58	5433	31.22	5719	32.87
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	4471	25.70	4769	27.41	5067	29.12	5365	30.83	5663	32.55	5961	34.26
Laborer (Maintenance) (IDOT)	23080	B	4426	25.44	4721	27.13	5016	28.83	5311	30.52	5606	32.22	5901	33.91
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	4500	25.86	4800	27.59	5100	29.31	5400	31.03	5700	32.76	6000	34.48
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	4550	26.15	4853	27.89	5156	29.63	5459	31.37	5763	33.12	6173	35.48
Maintenance Equipment	25020	S	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6227	35.79

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Operator (DOC - Maximum Security)														
Maintenance Equipment Operator (DHS - Forensics)	25020	Q	4670	26.84	4982	28.63	5293	30.42	5604	32.21	5916	34.00	6066	34.86
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	4454	25.60	4751	27.30	5048	29.01	5345	30.72	5642	32.43	5939	34.13
Maintenance Worker (DHS - Forensics)	25500	Q	4505	25.89	4805	27.61	5105	29.34	5405	31.06	5706	32.79	6006	34.52
Power Shovel Operator (Maintenance) (Regular - RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	4580	26.32	4885	28.07	5190	29.83	5495	31.58	5801	33.34	6106	35.09
Power Shovel Operator (Maintenance) (Regular - RG) (IDOT)	33360	Q	4630	26.61	4938	28.38	5247	30.16	5556	31.93	5864	33.70	6173	35.48
Power Shovel Operator (Maintenance) (Bridge Crew - BC) (IDOT)	33360	Q	4688	26.94	5000	28.74	5313	30.53	5625	32.33	5938	34.13	6250	35.92
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	4286	24.63	4572	26.28	4858	27.92	5144	29.56	5429	31.20	5715	32.84
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	4325	24.86	4613	26.51	4901	28.17	5189	29.82	5478	31.48	5766	33.14

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Silk Screen Operator (IDOT)	41020	B	4583	26.34	4889	28.10	5194	29.85	5500	31.61	5805	33.36	6111	35.12

Effective July 1, 2014

Title	Title	Pay Plan Code	75%		80%		85%		90%		95%		Full Scale	
			Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.	Mo.	Hr.
Bridge Mechanic (IDOT)	05310	Q	4668	26.83	4979	28.61	5290	30.40	5602	32.20	5913	33.98	6224	35.77
Bridge Tender (IDOT)	05320	B	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Deck Hand (IDOT)	11500	B	4512	25.93	4813	27.66	5114	29.39	5414	31.11	5715	32.84	6016	34.57
Ferry Operator I (IDOT)	14801	B	4696	26.99	5009	28.79	5322	30.59	5635	32.39	5948	34.18	6261	35.98
Ferry Operator II (IDOT)	14802	B	4736	27.22	5052	29.03	5368	30.85	5684	32.67	5999	34.48	6315	36.29
Highway Maintainer (Regular - RG) (IDOT)	18639	Q	4640	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6187	35.56
Highway Maintainer (Bridge Crew - BC) (IDOT)	18639	Q	4699	27.01	5012	28.80	5325	30.60	5639	32.41	5952	34.21	6265	36.01
Highway Maintainer (Drill Rig - DR) (IDOT)	18639	Q	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6296	36.18
Highway Maintainer (Emergency Patrol - EP) (IDOT)	18639	Q	4724	27.15	5039	28.96	5354	30.77	5669	32.58	5984	34.39	6299	36.20
Highway Maintenance Lead Worker (Regular - RG) (IDOT)	18659	Q	4748	27.29	5065	29.11	5381	30.93	5698	32.75	6014	34.56	6331	36.39

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Highway Maintenance Lead Worker (Bridge Crew - BC) (IDOT)	18659	Q	4806	27.62	5126	29.46	5447	31.30	5767	33.14	6088	34.99	6408	36.83
Highway Maintenance Lead Worker (Emergency Patrol - EP) (IDOT)	18659	Q	4832	27.77	5154	29.62	5476	31.47	5798	33.32	6120	35.17	6442	37.02
Highway Maintenance Lead Worker (Lead Lead Worker) (Regular - RG) (IDOT)	18659	Q	4790	27.53	5109	29.36	5428	31.20	5747	33.03	6067	34.87	6386	36.70
Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew - BC) (IDOT)	18659	Q	4847	27.86	5170	29.71	5494	31.57	5817	33.43	6140	35.29	6463	37.14
Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol - EP) (IDOT)	18659	Q	4851	27.88	5174	29.74	5498	31.60	5821	33.45	6145	35.32	6468	37.17
Janitor I (Including Office of Administration) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	21951	B	4349	24.99	4639	26.66	4929	28.33	5219	29.99	5509	31.66	5799	33.33
Janitor II (Including Office of Administration) (CMS, DOC,	21952	B	4375	25.14	4666	26.82	4958	28.49	5250	30.17	5541	31.84	5833	33.52

DHS, DJJ, DNR, ISP and DVA)														
Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	22809	B	4560	26.21	4864	27.95	5168	29.70	5472	31.45	5776	33.20	6080	34.94
Laborer (Maintenance) (IDOT)	23080	B	4514	25.94	4815	27.67	5116	29.40	5417	31.13	5718	32.86	6019	34.59
Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	25020	B	4590	26.38	4896	28.14	5202	29.90	5508	31.66	5814	33.41	6120	35.17
Maintenance Equipment Operator (DOC & DJJ)	25020	Q	4640	26.67	4950	28.45	5259	30.22	5568	32.00	5878	33.78	6296	36.18
Maintenance Equipment Operator (DOC - Maximum Security)	25020	S	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6352	36.51
Maintenance Equipment Operator (DHS - Forensics)	25020	Q	4764	27.38	5082	29.21	5399	31.03	5717	32.86	6034	34.68	6187	35.56
Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)	25500	B	4544	26.11	4846	27.85	5149	29.59	5452	31.33	5755	33.07	6058	34.82
Maintenance Worker (DHS - Forensics)	25500	Q	4595	26.41	4901	28.17	5207	29.93	5513	31.68	5820	33.45	6126	35.21

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Power Shovel Operator (Maintenance) (Regular - RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	33360	B	4671	26.84	4982	28.63	5294	30.43	5605	32.21	5917	34.01	6228	35.79
Power Shovel Operator (Maintenance) (Regular - RG) (IDOT)	33360	Q	4722	27.14	5037	28.95	5352	30.76	5666	32.56	5981	34.37	6296	36.18
Power Shovel Operator (Maintenance) (Bridge Crew - BC) (IDOT)	33360	Q	4781	27.48	5100	29.31	5419	31.14	5738	32.98	6056	34.80	6375	36.64
Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39851	B	4372	25.13	4663	26.80	4955	28.48	5246	30.15	5538	31.83	5829	33.50
Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)	39852	B	4411	25.35	4705	27.04	4999	28.73	5293	30.42	5587	32.11	5881	33.80
Silk Screen Operator (IDOT)	41020	B	4675	26.87	4986	28.66	5298	30.45	5610	32.24	5921	34.03	6233	35.82

~~Title~~	~~Title Code~~	~~Bargaining Unit~~	~~Pay Plan Code~~	~~July 1, 2012~~		~~July 1, 2013~~		~~July 1, 2014~~	
				~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~
~~Bridge Mechanic (IDOT)~~	~~05310~~	~~RC-019~~	~~Q~~	~~5982~~	~~34.38~~	~~6102~~	~~35.07~~	~~6224~~	~~35.77~~
~~Bridge Tender (IDOT)~~	~~05320~~	~~RC-019~~	~~B~~	~~6018~~	~~34.59~~	~~6138~~	~~35.28~~	~~6261~~	~~35.98~~
~~Deck Hand (IDOT)~~	~~11500~~	~~RC-019~~	~~B~~	~~5782~~	~~33.23~~	~~5898~~	~~33.90~~	~~6016~~	~~34.57~~
~~Ferry Operator I (IDOT)~~	~~14801~~	~~RC-019~~	~~B~~	~~6018~~	~~34.59~~	~~6138~~	~~35.28~~	~~6261~~	~~35.98~~
~~Ferry Operator II (IDOT)~~	~~14802~~	~~RC-019~~	~~B~~	~~6070~~	~~34.89~~	~~6191~~	~~35.58~~	~~6315~~	~~36.29~~
~~Highway Maintainer (Regular – RG) (IDOT)~~	~~18639~~	~~RC-019~~	~~Q~~	~~5947~~	~~34.18~~	~~6066~~	~~34.86~~	~~6187~~	~~35.56~~

~~Highway Maintainer (Bridge Crew = BC) (IDOT)~~	~~18639~~	~~RC-019~~	~~Q~~	~~6022~~	~~34.61~~	~~6142~~	~~35.30~~	~~6265~~	~~36.01~~
~~Highway Maintainer (Drill Rig - DR) (IDOT)~~	~~18639~~	~~RC-019~~	~~Q~~	~~6052~~	~~34.78~~	~~6173~~	~~35.48~~	~~6296~~	~~36.18~~
~~Highway Maintainer (Emergency Patrol = EP) (IDOT)~~	~~18639~~	~~RC-019~~	~~Q~~	~~6054~~	~~34.79~~	~~6175~~	~~35.49~~	~~6299~~	~~36.20~~
~~Highway Maintenance Lead Worker (Regular = RG) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6085~~	~~34.97~~	~~6207~~	~~35.67~~	~~6331~~	~~36.39~~
~~Highway Maintenance Lead Worker (Bridge Crew = BC) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6159~~	~~35.40~~	~~6282~~	~~36.10~~	~~6408~~	~~36.83~~
~~Highway Maintenance Lead Worker (Emergency Patrol = EP) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6192~~	~~35.59~~	~~6316~~	~~36.30~~	~~6442~~	~~37.02~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Regular = RG) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6138~~	~~35.28~~	~~6261~~	~~35.98~~	~~6386~~	~~36.70~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew = BC) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6212~~	~~35.70~~	~~6336~~	~~36.41~~	~~6463~~	~~37.14~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol = EP) (IDOT)~~	~~18659~~	~~RC-019~~	~~Q~~	~~6217~~	~~35.73~~	~~6341~~	~~36.44~~	~~6468~~	~~37.17~~
~~Janitor I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~21951~~	~~RC-019~~	~~B~~	~~5574~~	~~32.03~~	~~5685~~	~~32.67~~	~~5799~~	~~33.33~~
~~Janitor II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~21952~~	~~RC-019~~	~~B~~	~~5607~~	~~32.22~~	~~5719~~	~~32.87~~	~~5833~~	~~33.52~~
~~Labor Maintenance Lead Worker (CMS, DOC,~~	~~22809~~	~~RC-019~~	~~B~~	~~5844~~	~~33.59~~	~~5961~~	~~34.26~~	~~6080~~	~~34.94~~

~~DHS, DJJ, DNR, IDOT, ISP and DVA)~~									
~~Laborer (Maintenance) (IDOT)~~	~~23080~~	~~RC-019~~	~~B~~	~~5785~~	~~33.25~~	~~5901~~	~~33.91~~	~~6019~~	~~34.59~~
~~Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~25020~~	~~RC-019~~	~~B~~	~~5882~~	~~33.80~~	~~6000~~	~~34.48~~	~~6120~~	~~35.17~~
~~Maintenance Equipment Operator (DOC & DJJ)~~	~~25020~~	~~RC-019~~	~~Q~~	~~6052~~	~~34.78~~	~~6173~~	~~35.48~~	~~6296~~	~~36.18~~
~~Maintenance Equipment Operator (DOC – Maximum Security)~~	~~25020~~	~~RC-019~~	~~S~~	~~6105~~	~~35.09~~	~~6227~~	~~35.79~~	~~6352~~	~~36.51~~
~~Maintenance Equipment Operator (DHS – Forensics)~~	~~25020~~	~~RC-019~~	~~Q~~	~~5947~~	~~34.18~~	~~6066~~	~~34.86~~	~~6187~~	~~35.56~~
~~Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)~~	~~25500~~	~~RC-019~~	~~B~~	~~5823~~	~~33.47~~	~~5939~~	~~34.13~~	~~6058~~	~~34.82~~
~~Maintenance Worker (DHS – Forensics)~~	~~25500~~	~~RC-019~~	~~Q~~	~~5888~~	~~33.84~~	~~6006~~	~~34.52~~	~~6126~~	~~35.21~~
~~Power Shovel Operator (Maintenance) (Regular – RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~33360~~	~~RC-019~~	~~B~~	~~5986~~	~~34.40~~	~~6106~~	~~35.09~~	~~6228~~	~~35.79~~
~~Power Shovel Operator (Maintenance) (Regular – RG) (IDOT)~~	~~33360~~	~~RC-019~~	~~Q~~	~~6052~~	~~34.78~~	~~6173~~	~~35.48~~	~~6296~~	~~36.18~~
~~Power Shovel Operator (Maintenance) (Bridge Crew – BC) (IDOT)~~	~~33360~~	~~RC-019~~	~~Q~~	~~6127~~	~~35.21~~	~~6250~~	~~35.92~~	~~6375~~	~~36.64~~
~~Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~39851~~	~~RC-019~~	~~B~~	~~5603~~	~~32.20~~	~~5715~~	~~32.84~~	~~5829~~	~~33.50~~
~~Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~39852~~	~~RC-019~~	~~B~~	~~5653~~	~~32.49~~	~~5766~~	~~33.14~~	~~5881~~	~~33.80~~

~~Silk Screen Operator (IDOT)~~		~~41020~~	~~RC-019~~	~~B~~	~~5991~~	~~34.43~~	~~6111~~	~~35.12~~	~~6233~~	~~35.82~~	

~~New Hire Rates~~

~~Effective July 1, 2012~~

~~Title~~	~~Pay Plan Code~~	~~95%~~		~~90%~~		~~85%~~		~~80%~~		~~75%~~	
		~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~
~~Highway Maintainer (Regular – RG) (IDOT)~~	~~Q~~	~~5650~~	~~32.47~~	~~5352~~	~~30.76~~	~~5055~~	~~29.05~~	~~4758~~	~~27.34~~	~~4460~~	~~25.63~~
~~Highway Maintainer (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~5721~~	~~32.88~~	~~5420~~	~~31.15~~	~~5119~~	~~29.42~~	~~4818~~	~~27.69~~	~~4517~~	~~25.96~~
~~Highway Maintainer (Drill Rig – DR) (IDOT)~~	~~Q~~	~~5749~~	~~33.04~~	~~5447~~	~~31.30~~	~~5144~~	~~29.56~~	~~4842~~	~~27.83~~	~~4539~~	~~26.09~~
~~Highway Maintainer (Emergency Patrol – EP) (IDOT)~~	~~Q~~	~~5751~~	~~33.05~~	~~5449~~	~~31.32~~	~~5146~~	~~29.57~~	~~4843~~	~~27.83~~	~~4541~~	~~26.10~~

~~Effective July 1, 2013~~

~~Title~~	~~Pay Plan Code~~	~~95%~~		~~90%~~		~~85%~~		~~80%~~		~~75%~~	
		~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~
~~Bridge Mechanic (IDOT)~~	~~Q~~	~~5797~~	~~33.32~~	~~5492~~	~~31.56~~	~~5187~~	~~29.81~~	~~4882~~	~~28.06~~	~~4577~~	~~26.30~~
~~Bridge Tender (IDOT)~~	~~B~~	~~5831~~	~~33.51~~	~~5524~~	~~31.75~~	~~5217~~	~~29.98~~	~~4910~~	~~28.22~~	~~4604~~	~~26.46~~
~~Deck Hand (IDOT)~~	~~B~~	~~5603~~	~~32.20~~	~~5308~~	~~30.51~~	~~5013~~	~~28.81~~	~~4718~~	~~27.11~~	~~4424~~	~~25.43~~
~~Ferry Operator I (IDOT)~~	~~B~~	~~5831~~	~~33.51~~	~~5524~~	~~31.75~~	~~5217~~	~~29.98~~	~~4910~~	~~28.22~~	~~4604~~	~~26.46~~

~~Ferry Operator II (IDOT)~~	~~B~~	~~5881~~	~~33.80~~	~~5572~~	~~32.02~~	~~5262~~	~~30.24~~	~~4953~~	~~28.47~~	~~4643~~	~~26.68~~
~~Highway Maintainer (Regular – RG) (IDOT)~~	~~Q~~	~~5763~~	~~33.12~~	~~5459~~	~~31.37~~	~~5156~~	~~29.63~~	~~4853~~	~~27.89~~	~~4550~~	~~26.15~~
~~Highway Maintainer (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~5835~~	~~33.53~~	~~5528~~	~~31.77~~	~~5221~~	~~30.01~~	~~4914~~	~~28.24~~	~~4607~~	~~26.48~~
~~Highway Maintainer (Drill Rig – DR) (IDOT)~~	~~Q~~	~~5864~~	~~33.70~~	~~5556~~	~~31.93~~	~~5247~~	~~30.16~~	~~4938~~	~~28.38~~	~~4630~~	~~26.61~~
~~Highway Maintainer (Emergency Patrol – EP) (IDOT)~~	~~Q~~	~~5866~~	~~33.71~~	~~5558~~	~~31.94~~	~~5249~~	~~30.17~~	~~4940~~	~~28.39~~	~~4631~~	~~26.61~~
~~Highway Maintenance Lead Worker (Regular – RG) (IDOT)~~	~~Q~~	~~5897~~	~~33.89~~	~~5586~~	~~32.10~~	~~5276~~	~~30.32~~	~~4966~~	~~28.54~~	~~4655~~	~~26.75~~
~~Highway Maintenance Lead Worker (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~5968~~	~~34.30~~	~~5654~~	~~32.49~~	~~5340~~	~~30.69~~	~~5026~~	~~28.89~~	~~4712~~	~~27.08~~
~~Highway Maintenance Lead Worker (Emergency Patrol – EP) (IDOT)~~	~~Q~~	~~6000~~	~~34.48~~	~~5684~~	~~32.67~~	~~5369~~	~~30.86~~	~~5053~~	~~29.04~~	~~4737~~	~~27.22~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Regular – RG) (IDOT)~~	~~Q~~	~~5948~~	~~34.18~~	~~5635~~	~~32.39~~	~~5322~~	~~30.59~~	~~5009~~	~~28.79~~	~~4696~~	~~26.99~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~6019~~	~~34.59~~	~~5702~~	~~32.77~~	~~5386~~	~~30.95~~	~~5069~~	~~29.13~~	~~4752~~	~~27.31~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol – EP) (IDOT)~~	~~Q~~	~~6024~~	~~34.62~~	~~5707~~	~~32.80~~	~~5390~~	~~30.98~~	~~5073~~	~~29.16~~	~~4756~~	~~27.33~~

~~Janitor I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5401~~	~~31.04~~	~~5117~~	~~29.41~~	~~4832~~	~~27.77~~	~~4548~~	~~26.14~~	~~4264~~	~~24.51~~
~~Janitor II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5433~~	~~31.22~~	~~5147~~	~~29.58~~	~~4861~~	~~27.94~~	~~4575~~	~~26.29~~	~~4289~~	~~24.65~~
~~Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)~~	~~B~~	~~5663~~	~~32.55~~	~~5365~~	~~30.83~~	~~5067~~	~~29.12~~	~~4769~~	~~27.41~~	~~4471~~	~~25.70~~
~~Laborer (Maintenance) (IDOT)~~	~~B~~	~~5606~~	~~32.22~~	~~5311~~	~~30.52~~	~~5016~~	~~28.83~~	~~4721~~	~~27.13~~	~~4426~~	~~25.44~~
~~Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5700~~	~~32.76~~	~~5400~~	~~31.03~~	~~5100~~	~~29.31~~	~~4800~~	~~27.59~~	~~4500~~	~~25.86~~
~~Maintenance Equipment Operator (DOC & DJJ)~~	~~Q~~	~~5763~~	~~33.12~~	~~5459~~	~~31.37~~	~~5156~~	~~29.63~~	~~4853~~	~~27.89~~	~~4550~~	~~26.15~~
~~Maintenance Equipment Operator (DOC – Maximum Security)~~	~~S~~	~~5864~~	~~33.70~~	~~5556~~	~~31.93~~	~~5247~~	~~30.16~~	~~4938~~	~~28.38~~	~~4630~~	~~26.61~~
~~Maintenance Equipment Operator (DHS – Forensics)~~	~~Q~~	~~5916~~	~~34.00~~	~~5604~~	~~32.21~~	~~5293~~	~~30.42~~	~~4982~~	~~28.63~~	~~4670~~	~~26.84~~
~~Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)~~	~~B~~	~~5642~~	~~32.43~~	~~5345~~	~~30.72~~	~~5048~~	~~29.01~~	~~4751~~	~~27.30~~	~~4454~~	~~25.60~~
~~Maintenance Worker (DHS – Forensics)~~	~~Q~~	~~5706~~	~~32.79~~	~~5405~~	~~31.06~~	~~5105~~	~~29.34~~	~~4805~~	~~27.61~~	~~4505~~	~~25.89~~
~~Power Shovel Operator (Maintenance) (Regular – RG) (CMS, DOC, DHS,~~	~~B~~	~~5801~~	~~33.34~~	~~5495~~	~~31.58~~	~~5190~~	~~29.83~~	~~4885~~	~~28.07~~	~~4580~~	~~26.32~~

~~DJJ, DNR, ISP and DVA)~~											
~~Power Shovel Operator (Maintenance) (Regular – RG) (IDOT)~~	~~Q~~	~~5864~~	~~33.70~~	~~5556~~	~~31.93~~	~~5247~~	~~30.16~~	~~4938~~	~~28.38~~	~~4630~~	~~26.61~~
~~Power Shovel Operator (Maintenance) (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~5938~~	~~34.13~~	~~5625~~	~~32.33~~	~~5313~~	~~30.53~~	~~5000~~	~~28.74~~	~~4688~~	~~26.94~~
~~Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5429~~	~~31.20~~	~~5144~~	~~29.56~~	~~4858~~	~~27.92~~	~~4572~~	~~26.28~~	~~4286~~	~~24.63~~
~~Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5478~~	~~31.48~~	~~5189~~	~~29.82~~	~~4901~~	~~28.17~~	~~4613~~	~~26.51~~	~~4325~~	~~24.86~~
~~Silk Screen Operator (IDOT)~~	~~B~~	~~5805~~	~~33.36~~	~~5500~~	~~31.61~~	~~5194~~	~~29.85~~	~~4889~~	~~28.10~~	~~4583~~	~~26.34~~

~~Effective July 1, 2014~~

~~Title~~	~~Pay Plan Code~~	~~95%~~		~~90%~~		~~85%~~		~~80%~~		~~75%~~	
		~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~	~~Mo.~~	~~Hr.~~
~~Bridge Mechanic (IDOT)~~	~~Q~~	~~5913~~	~~33.98~~	~~5602~~	~~32.20~~	~~5290~~	~~30.40~~	~~4979~~	~~28.61~~	~~4668~~	~~26.83~~
~~Bridge Tender (IDOT)~~	~~B~~	~~5948~~	~~34.18~~	~~5635~~	~~32.39~~	~~5322~~	~~30.59~~	~~5009~~	~~28.79~~	~~4696~~	~~26.99~~
~~Deck Hand (IDOT)~~	~~B~~	~~5715~~	~~32.84~~	~~5414~~	~~31.11~~	~~5114~~	~~29.39~~	~~4813~~	~~27.66~~	~~4512~~	~~25.93~~
~~Ferry Operator I (IDOT)~~	~~B~~	~~5948~~	~~34.18~~	~~5635~~	~~32.39~~	~~5322~~	~~30.59~~	~~5009~~	~~28.79~~	~~4696~~	~~26.99~~
~~Ferry Operator II (IDOT)~~	~~B~~	~~5999~~	~~34.48~~	~~5684~~	~~32.67~~	~~5368~~	~~30.85~~	~~5052~~	~~29.03~~	~~4736~~	~~27.22~~

~~Highway Maintainer (Regular = RG) (IDOT)~~	~~Q~~	~~5878~~	~~33.78~~	~~5568~~	~~32.00~~	~~5259~~	~~30.22~~	~~4950~~	~~28.45~~	~~4640~~	~~26.67~~
~~Highway Maintainer (Bridge Crew = BC) (IDOT)~~	~~Q~~	~~5952~~	~~34.21~~	~~5639~~	~~32.41~~	~~5325~~	~~30.60~~	~~5012~~	~~28.80~~	~~4699~~	~~27.01~~
~~Highway Maintainer (Drill Rig = DR) (IDOT)~~	~~Q~~	~~5981~~	~~34.37~~	~~5666~~	~~32.56~~	~~5352~~	~~30.76~~	~~5037~~	~~28.95~~	~~4722~~	~~27.14~~
~~Highway Maintainer (Emergency Patrol = EP) (IDOT)~~	~~Q~~	~~5984~~	~~34.39~~	~~5669~~	~~32.58~~	~~5354~~	~~30.77~~	~~5039~~	~~28.96~~	~~4724~~	~~27.15~~
~~Highway Maintenance Lead Worker (Regular = RG) (IDOT)~~	~~Q~~	~~6014~~	~~34.56~~	~~5698~~	~~32.75~~	~~5381~~	~~30.93~~	~~5065~~	~~29.11~~	~~4748~~	~~27.29~~
~~Highway Maintenance Lead Worker (Bridge Crew = BC) (IDOT)~~	~~Q~~	~~6088~~	~~34.99~~	~~5767~~	~~33.14~~	~~5447~~	~~31.30~~	~~5126~~	~~29.46~~	~~4806~~	~~27.62~~
~~Highway Maintenance Lead Worker (Emergency Patrol = EP) (IDOT)~~	~~Q~~	~~6120~~	~~35.17~~	~~5798~~	~~33.32~~	~~5476~~	~~31.47~~	~~5154~~	~~29.62~~	~~4832~~	~~27.77~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Regular = RG) (IDOT)~~	~~Q~~	~~6067~~	~~34.87~~	~~5747~~	~~33.03~~	~~5428~~	~~31.20~~	~~5109~~	~~29.36~~	~~4790~~	~~27.53~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Bridge Crew = BC) (IDOT)~~	~~Q~~	~~6140~~	~~35.29~~	~~5817~~	~~33.43~~	~~5494~~	~~31.57~~	~~5170~~	~~29.71~~	~~4847~~	~~27.86~~
~~Highway Maintenance Lead Worker (Lead Lead Worker) (Emergency Patrol = EP) (IDOT)~~	~~Q~~	~~6145~~	~~35.32~~	~~5821~~	~~33.45~~	~~5498~~	~~31.60~~	~~5174~~	~~29.74~~	~~4851~~	~~27.88~~
~~Janitor I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5509~~	~~31.66~~	~~5219~~	~~29.99~~	~~4929~~	~~28.33~~	~~4639~~	~~26.66~~	~~4349~~	~~24.99~~

~~Janitor II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5541~~	~~31.84~~	~~5250~~	~~30.17~~	~~4958~~	~~28.49~~	~~4666~~	~~26.82~~	~~4375~~	~~25.14~~
~~Labor Maintenance Lead Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)~~	~~B~~	~~5776~~	~~33.20~~	~~5472~~	~~31.45~~	~~5168~~	~~29.70~~	~~4864~~	~~27.95~~	~~4560~~	~~26.21~~
~~Laborer (Maintenance) (IDOT)~~	~~B~~	~~5718~~	~~32.86~~	~~5417~~	~~31.13~~	~~5116~~	~~29.40~~	~~4815~~	~~27.67~~	~~4514~~	~~25.94~~
~~Maintenance Equipment Operator (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5814~~	~~33.41~~	~~5508~~	~~31.66~~	~~5202~~	~~29.90~~	~~4896~~	~~28.14~~	~~4590~~	~~26.38~~
~~Maintenance Equipment Operator (DOC & DJJ)~~	~~Q~~	~~5878~~	~~33.78~~	~~5568~~	~~32.00~~	~~5259~~	~~30.22~~	~~4950~~	~~28.45~~	~~4640~~	~~26.67~~
~~Maintenance Equipment Operator (DOC – Maximum Security)~~	~~S~~	~~5981~~	~~34.37~~	~~5666~~	~~32.56~~	~~5352~~	~~30.76~~	~~5037~~	~~28.95~~	~~4722~~	~~27.14~~
~~Maintenance Equipment Operator (DHS – Forensics)~~	~~Q~~	~~6034~~	~~34.68~~	~~5717~~	~~32.86~~	~~5399~~	~~31.03~~	~~5082~~	~~29.21~~	~~4764~~	~~27.38~~
~~Maintenance Worker (CMS, DOC, DHS, DJJ, DNR, IDOT, ISP and DVA)~~	~~B~~	~~5755~~	~~33.07~~	~~5452~~	~~31.33~~	~~5149~~	~~29.59~~	~~4846~~	~~27.85~~	~~4544~~	~~26.11~~
~~Maintenance Worker (DHS – Forensics)~~	~~Q~~	~~5820~~	~~33.45~~	~~5513~~	~~31.68~~	~~5207~~	~~29.93~~	~~4901~~	~~28.17~~	~~4595~~	~~26.41~~
~~Power Shovel Operator (Maintenance) (Regular – RG) (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5917~~	~~34.01~~	~~5605~~	~~32.21~~	~~5294~~	~~30.43~~	~~4982~~	~~28.63~~	~~4671~~	~~26.84~~

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

~~Power Shovel Operator (Maintenance) (Regular – RG) (IDOT)~~	~~Q~~	~~5981~~	~~34.37~~	~~5666~~	~~32.56~~	~~5352~~	~~30.76~~	~~5037~~	~~28.95~~	~~4722~~	~~27.14~~
~~Power Shovel Operator (Maintenance) (Bridge Crew – BC) (IDOT)~~	~~Q~~	~~6056~~	~~34.80~~	~~5738~~	~~32.98~~	~~5419~~	~~31.14~~	~~5100~~	~~29.31~~	~~4781~~	~~27.48~~
~~Security Guard I (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5538~~	~~31.83~~	~~5246~~	~~30.15~~	~~4955~~	~~28.48~~	~~4663~~	~~26.80~~	~~4372~~	~~25.13~~
~~Security Guard II (CMS, DOC, DHS, DJJ, DNR, ISP and DVA)~~	~~B~~	~~5587~~	~~32.11~~	~~5293~~	~~30.42~~	~~4999~~	~~28.73~~	~~4705~~	~~27.04~~	~~4411~~	~~25.35~~
~~Silk Screen Operator (IDOT)~~	~~B~~	~~5921~~	~~34.03~~	~~5610~~	~~32.24~~	~~5298~~	~~30.45~~	~~4986~~	~~28.66~~	~~4675~~	~~26.87~~

NOTE
~~Note~~: Effective July 1, 2011, the clothing allowance for Highway Maintainers, Highway Maintenance Lead Workers, Highway Maintenance Lead Lead Workers, Deck Hands and Power Shovel Operator Maintenance employees increases to $200. Effective July 1, 2011, the clothing allowance for all other titles increases to $100. Effective July 1, 2013, employees who are required to wear steel-toe safety shoes shall receive an additional $100 clothing allowance. The total will not exceed $200 per contract year.

Employees shall receive a one-time 2.25% stipend that~~which~~ will not be added into the base salary effective June 1, 2013. Permanent part-time employees will be paid a prorated~~pro-rated~~ stipend based upon their regular work schedule which will not be added into the base salary. To be eligible for the stipend, the employee must be on payroll June 1, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend to which they are entitled upon return to the active payroll during fiscal year 2013. An employee~~,~~ who worked during fiscal year 2013~~, which dates are~~ (July 1, 2012 through June 30, 2013)~~,~~ and was~~were~~ on an authorized Worker's Compensation Leave of Absence, shall be paid the fiscal year 2013 stipend upon the employee's~~their~~ official return to work sometime during fiscal year 2014,

unless otherwise compensated for the stipend. Return to work is defined as the employee's first day back to active payroll status with an authorized licensed physician's release.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE G RC-045 (Automotive Mechanics, IFPE)

Effective ~~Date~~ July 1, 2012

Title	Title Code	Pay Plan Code	Monthly Rate
Auto & Body Repairer	03680	B	5432
Auto & Body Repairer	03680	Q	5624
Auto & Body Repairer	03680	S	5704
Automotive Attendant I	03696	B	3281
Automotive Attendant I	03696	Q	3411
Automotive Attendant I	03696	S	3484
Automotive Attendant II	03697	B	3504
Automotive Attendant II	03697	Q	3642
Automotive Attendant II	03697	S	3714
Automotive Mechanic	03700	B	5432
Automotive Mechanic	03700	Q	5624
Automotive Mechanic	03700	S	5704
Automotive Mechanic (Hired on or after 9/1/2010)	03700	B	5052
Automotive Mechanic (Hired on or after 9/1/2010)	03700	Q	5230
Automotive Mechanic (Hired on or after 9/1/2010)	03700	S	5305
Automotive Parts Warehouse Specialist	03734	B	5319
Automotive Parts Warehouser	03730	B	5218
Small Engine Mechanic	41150	B	4782
Storekeeper I*	43051	B	5112
Storekeeper II*	43052	B	5221

Effective ~~Date~~ July 1, 2013

Title	Title Code	Pay Plan Code	93%	95%	97%	100% (Full-Scale)
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	B	5153	5264	5375	5541

Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	Q	5230	5343	5455	5624
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	S	5305	5419	5533	5704

~~Title~~	~~Title Code~~	~~Pay Plan Code~~	~~100% (Full-Scale)~~	~~97%~~	~~95%~~	~~93%~~
~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~B~~	~~5541~~	~~5375~~	~~5264~~	~~5153~~
~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~Q~~	~~5624~~	~~5455~~	~~5343~~	~~5230~~
~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~S~~	~~5704~~	~~5533~~	~~5419~~	~~5305~~

Title	Title Code	Pay Plan Code	75%	80%	85%	90%	95%	100% (Full-Scale)
Auto & Body Repairer	03680	B	4156	4433	4710	4987	5264	5541
Auto & Body Repairer	03680	Q	4218	4499	4780	5062	5343	5624
Auto & Body Repairer	03680	S	4278	4563	4848	5134	5419	5704
Automotive Attendant I	03696	B	2510	2678	2845	3012	3180	3347
Automotive Attendant I	03696	Q	2558	2729	2899	3070	3240	3411
Automotive Attendant I	03696	S	2613	2787	2961	3136	3310	3484
Automotive Attendant II	03697	B	2681	2859	3038	3217	3395	3574
Automotive Attendant II	03697	Q	2732	2914	3096	3278	3460	3642
Automotive Attendant II	03697	S	2786	2971	3157	3343	3528	3714
Automotive Mechanic	03700	B	4156	4433	4710	4987	5264	5541
Automotive Mechanic	03700	Q	4218	4499	4780	5062	5343	5624
Automotive Mechanic	03700	S	4278	4563	4848	5134	5419	5704
Automotive Parts Warehouse Specialist	03734	B	4069	4340	4611	4883	5154	5425
Automotive Parts Warehouser	03730	B	3992	4258	4524	4790	5056	5322
Small Engine Mechanic	41150	B	3659	3902	4146	4390	4634	4878
Storekeeper I*	43051	B	3911	4171	4432	4693	4953	5214

Storekeeper II*	43052	B	3994	4260	4526	4793	5059	5325

~~Title~~	~~Title Code~~	~~Pay Plan Code~~	~~100% (Full Scale)~~	~~95%~~	~~90%~~	~~85%~~	~~80%~~	~~75%~~
~~Auto & Body Repairer~~	~~03680~~	~~B~~	~~5541~~	~~5264~~	~~4987~~	~~4710~~	~~4433~~	~~4156~~
~~Auto & Body Repairer~~	~~03680~~	~~Q~~	~~5624~~	~~5343~~	~~5062~~	~~4780~~	~~4499~~	~~4218~~
~~Auto & Body Repairer~~	~~03680~~	~~S~~	~~5704~~	~~5419~~	~~5134~~	~~4848~~	~~4563~~	~~4278~~
~~Automotive Attendant I~~	~~03696~~	~~B~~	~~3347~~	~~3180~~	~~3012~~	~~2845~~	~~2678~~	~~2510~~
~~Automotive Attendant I~~	~~03696~~	~~Q~~	~~3411~~	~~3240~~	~~3070~~	~~2899~~	~~2729~~	~~2558~~
~~Automotive Attendant I~~	~~03696~~	~~S~~	~~3484~~	~~3310~~	~~3136~~	~~2961~~	~~2787~~	~~2613~~
~~Automotive Attendant II~~	~~03697~~	~~B~~	~~3574~~	~~3395~~	~~3217~~	~~3038~~	~~2859~~	~~2681~~
~~Automotive Attendant II~~	~~03697~~	~~Q~~	~~3642~~	~~3460~~	~~3278~~	~~3096~~	~~2914~~	~~2732~~
~~Automotive Attendant II~~	~~03697~~	~~S~~	~~3714~~	~~3528~~	~~3343~~	~~3157~~	~~2971~~	~~2786~~
~~Automotive Mechanic~~	~~03700~~	~~B~~	~~5541~~	~~5264~~	~~4987~~	~~4710~~	~~4433~~	~~4156~~
~~Automotive Mechanic~~	~~03700~~	~~Q~~	~~5624~~	~~5343~~	~~5062~~	~~4780~~	~~4499~~	~~4218~~
~~Automotive Mechanic~~	~~03700~~	~~S~~	~~5704~~	~~5419~~	~~5134~~	~~4848~~	~~4563~~	~~4278~~
~~Automotive Parts Warehouse Specialist~~	~~03734~~	~~B~~	~~5425~~	~~5154~~	~~4883~~	~~4611~~	~~4340~~	~~4069~~
~~Automotive Parts Warehouser~~	~~03730~~	~~B~~	~~5322~~	~~5056~~	~~4790~~	~~4524~~	~~4258~~	~~3992~~
~~Small Engine Mechanic~~	~~41150~~	~~B~~	~~4878~~	~~4634~~	~~4390~~	~~4146~~	~~3902~~	~~3659~~
~~Storekeeper I*~~	~~43051~~	~~B~~	~~5214~~	~~4953~~	~~4693~~	~~4432~~	~~4171~~	~~3911~~
~~Storekeeper II*~~	~~43052~~	~~B~~	~~5325~~	~~5059~~	~~4793~~	~~4526~~	~~4260~~	~~3994~~

Effective ~~Date~~ July 1, 2014

Title	Title Code	Pay Plan Code	95%	97%	100% (Full-Scale)
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	B	5369	5482	5652
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	Q	5449	5564	5736
Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)	03700	S	5527	5643	5818

~~Title~~	~~Title Code~~	~~Pay Plan Code~~	~~100% (Full Scale)~~	~~97%~~	~~95%~~

~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~B~~	~~5652~~	~~5482~~	~~5369~~
~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~Q~~	~~5736~~	~~5564~~	~~5449~~
~~Automotive Mechanic (Hired between 9/1/2010 and 6/30/2013)~~	~~03700~~	~~S~~	~~5818~~	~~5643~~	~~5527~~

Title	Title Code	Pay Plan Code	75%	80%	85%	90%	95%	100% (Full-Scale)
Auto & Body Repairer	03680	B	4239	4522	4804	5087	5369	5652
Auto & Body Repairer	03680	Q	4302	4589	4876	5162	5449	5736
Auto & Body Repairer	03680	S	4364	4654	4945	5236	5527	5818
Automotive Attendant I	03696	B	2561	2731	2902	3073	3243	3414
Automotive Attendant I	03696	Q	2609	2783	2957	3131	3305	3479
Automotive Attendant I	03696	S	2666	2843	3021	3199	3376	3554
Automotive Attendant II	03697	B	2734	2916	3098	3281	3463	3645
Automotive Attendant II	03697	Q	2786	2972	3158	3344	3529	3715
Automotive Attendant II	03697	S	2841	3030	3220	3409	3599	3788
Automotive Mechanic	03700	B	4239	4522	4804	5087	5369	5652
Automotive Mechanic	03700	Q	4302	4589	4876	5162	5449	5736
Automotive Mechanic	03700	S	4364	4654	4945	5236	5527	5818
Automotive Parts Warehouse Specialist	03734	B	4151	4427	4704	4981	5257	5534
Automotive Parts Warehouser	03730	B	4071	4342	4614	4885	5157	5428
Small Engine Mechanic	41150	B	3732	3981	4230	4478	4727	4976
Storekeeper I*	43051	B	3989	4254	4520	4786	5052	5318
Storekeeper II*	43052	B	4074	4346	4617	4889	5160	5432

~~Title~~	~~Title Code~~	~~Pay Plan Code~~	~~100% (Full-Scale)~~	~~95%~~	~~90%~~	~~85%~~	~~80%~~	~~75%~~
~~Auto & Body Repairer~~	~~03680~~	~~B~~	~~5652~~	~~5369~~	~~5087~~	~~4804~~	~~4522~~	~~4239~~
~~Auto & Body Repairer~~	~~03680~~	~~Q~~	~~5736~~	~~5449~~	~~5162~~	~~4876~~	~~4589~~	~~4302~~

~~Auto & Body Repairer~~	~~03680~~	~~S~~	~~5818~~	~~5527~~	~~5236~~	~~4945~~	~~4654~~	~~4364~~
~~Automotive Attendant I~~	~~03696~~	~~B~~	~~3414~~	~~3243~~	~~3073~~	~~2902~~	~~2731~~	~~2561~~
~~Automotive Attendant I~~	~~03696~~	~~Q~~	~~3479~~	~~3305~~	~~3131~~	~~2957~~	~~2783~~	~~2609~~
~~Automotive Attendant I~~	~~03696~~	~~S~~	~~3554~~	~~3376~~	~~3199~~	~~3021~~	~~2843~~	~~2666~~
~~Automotive Attendant II~~	~~03697~~	~~B~~	~~3645~~	~~3463~~	~~3281~~	~~3098~~	~~2916~~	~~2734~~
~~Automotive Attendant II~~	~~03697~~	~~Q~~	~~3715~~	~~3529~~	~~3344~~	~~3158~~	~~2972~~	~~2786~~
~~Automotive Attendant II~~	~~03697~~	~~S~~	~~3788~~	~~3599~~	~~3409~~	~~3220~~	~~3030~~	~~2841~~
~~Automotive Mechanic~~	~~03700~~	~~B~~	~~5652~~	~~5369~~	~~5087~~	~~4804~~	~~4522~~	~~4239~~
~~Automotive Mechanic~~	~~03700~~	~~Q~~	~~5736~~	~~5449~~	~~5162~~	~~4876~~	~~4589~~	~~4302~~
~~Automotive Mechanic~~	~~03700~~	~~S~~	~~5818~~	~~5527~~	~~5236~~	~~4945~~	~~4654~~	~~4364~~
~~Automotive Parts Warehouse Specialist~~	~~03734~~	~~B~~	~~5534~~	~~5257~~	~~4981~~	~~4704~~	~~4427~~	~~4151~~
~~Automotive Parts Warehouser~~	~~03730~~	~~B~~	~~5428~~	~~5157~~	~~4885~~	~~4614~~	~~4342~~	~~4071~~
~~Small Engine Mechanic~~	~~41150~~	~~B~~	~~4976~~	~~4727~~	~~4478~~	~~4230~~	~~3981~~	~~3732~~
~~Storekeeper I*~~	~~43051~~	~~B~~	~~5318~~	~~5052~~	~~4786~~	~~4520~~	~~4254~~	~~3989~~
~~Storekeeper II*~~	~~43052~~	~~B~~	~~5432~~	~~5160~~	~~4889~~	~~4617~~	~~4346~~	~~4074~~

* Storekeeper I & Storekeeper II serving as Automotive Parts Warehouser in Cook County.

NOTE

~~Note~~: Effective July 1, 2011, employees who have more than 10 years of continuous service receive a longevity payment of $50/month and employees who have more than 15 years of continuous service receive a longevity payment of $75/month.

The Storekeeper I and II titles are in Cook County only.

An employee newly hired to a position that was previously covered by the alternative formula for pension benefits prior to January 1, 2011 and, effective January 1, 2011, is covered by the standard formula for pension benefits (see the Illinois Pension Code [40 ILCS 5/1-160(g) and 14-110(b)]) shall be placed on the Pay Plan Code B salary grade assigned to the classification to which the position is allocated. An employee newly hired is an employee hired on or after January 1, 2011 who has never been a member of the State Employees' Retirement System (SERS) or any other reciprocal retirement system. Other reciprocal retirement systems are the Chicago Teachers' Pension Fund, County Employees' Annuity and Benefit Fund of Cook County, Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, General Assembly Retirement System (GARS), Illinois Municipal Retirement Fund (IMRF), Judges Retirement

System (JRS), Laborers' Annuity and Benefit Fund of Chicago, Metropolitan Water Reclamation District Retirement Fund, Municipal Employees Annuity and Benefit Fund of Chicago, State Universities Retirement System (SURS) and Teachers' Retirement System of the State of Illinois (TRS).

Employees shall receive a one-time 2.25% stipend which will not be added into the base salary. The stipend is based on the employee's base salary effective June 28, 2013. Permanent part-time employees are paid a prorated~~pro-rated~~ stipend, based upon their regular work schedule, that is not to be added into the employee's base salary. To be eligible for the stipend, the employee shall be on the payroll June 28, 2013. Employees on leave of absence who would otherwise be eligible will receive the lump sum stipend upon return during fiscal year 2013 to the active payroll.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section 310.APPENDIX A Negotiated Rates of Pay

Section 310.TABLE Q RC-033 (Meat Inspectors, IFPE)

Title	Title Code	Bargaining Unit	Pay Plan Code
Meat and Poultry Inspector	26070	RC-033	B
Meat and Poultry Inspector Trainee	26075	RC-033	B

~~Effective July 1, 2011~~

	~~STEPS~~							
~~Title~~	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~
~~Meat and Poultry Inspector~~	~~3811~~	~~3977~~	~~4136~~	~~4293~~	~~4460~~	~~4710~~	~~4806~~	~~4854~~
~~Meat and Poultry Inspector Trainee~~	~~3233~~	~~3351~~	~~3479~~	~~3604~~	~~3730~~	~~3936~~	~~4013~~	~~4053~~

Effective July~~January~~ 1, 2012

	STEPS							
Title	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3859	4027	4188	4347	4516	4769	4866	4915
Meat and Poultry Inspector Trainee	3273	3393	3522	3649	3777	3985	4063	4104

Effective May 1, 2013

	STEPS										
Title	1c	1b	1a	1	2	3	4	5	6	7	8
Meat and Poultry Inspector	3512	3627	3743	3859	4027	4188	4347	4516	4769	4866	4915
Meat and Poultry Inspector Trainee	2978	3077	3175	3273	3393	3522	3649	3777	3985	4063	4104

Effective July 1, 2013

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

	STEPS										
Title	**1c**	**1b**	**1a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Meat and Poultry Inspector	3582	3700	3818	3936	4108	4272	4434	4606	4864	4963	5013
Meat and Poultry Inspector Trainee	3038	3139	3239	3338	3461	3592	3722	3853	4065	4144	4186

Effective July 1, 2014

	STEPS										
Title	**1c**	**1b**	**1a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Meat and Poultry Inspector	3654	3774	3894	4015	4190	4357	4523	4698	4961	5062	5113
Meat and Poultry Inspector Trainee	3099	3202	3304	3405	3530	3664	3796	3930	4146	4227	4270

NOTE
~~Note~~: An employee newly hired to a position that was previously covered by the alternative formula for pension benefits prior to January 1, 2011, and effective January 1, 2011, is covered by the standard formula for pension benefits (see the Illinois Pension Code [40 ILCS 5/1-160(g) and 14-110(b)])~~,~~ shall be placed on the Pay Plan Code B salary grade assigned to the classification to which the position is allocated. An employee newly hired is an employee hired on or after January 1, 2011 who has never been a member of the State Employees' Retirement System (SERS) or any other reciprocal retirement system. Other reciprocal retirement systems are the Chicago Teachers' Pension Fund, County Employees' Annuity and Benefit Fund of Cook County, Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, General Assembly Retirement System (GARS), Illinois Municipal Retirement Fund (IMRF), Judges Retirement System (JRS), Laborers' Annuity and Benefit Fund of Chicago, Metropolitan Water Reclamation District Retirement Fund, Municipal Employees Annuity and Benefit Fund of Chicago, State Universities Retirement System (SURS) and Teachers' Retirement System of the State of Illinois (TRS).

Employees whose official work county is Cook County and are on Step 1 through 7 as of July 1, 2011, receive a one-time step increase to be effective July 1, 2011.

Employees who are eligible for longevity pay at Step 7 on or before July 1, 2007 shall continue to receive longevity pay after being placed on Step 8 while they remain in the same pay grade. For employees not eligible to receive longevity pay on or before July 1, 2007, the Step 8 rate shall be increased by $25 per month for those employees who attain 10 years of continuous service and have 3 or more years of creditable service on Step 8 in the same pay grade. For those employees who attain 15 years of continuous service and have 3 or more years creditable service on Step 8 on the same pay grade, the Step 8 rate shall be increased by $50 per month. Effective July 1, 2013, the Step 8 rate shall be increased by $75 per month for those employees who attain 10 years of continuous service and have 3 or more years of creditable service on Step 8 of the same pay grade. For those employees who attain 15 years of continuous service and have 3 or more years of creditable service on the same pay grade, the Step 8 rate shall be increased by $100 per month.

(Source: Amended at 38 Ill. Reg. 5250, effective February 4, 2014)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: General Administrative Provisions

2) Code Citation: 89 Ill. Adm. Code 10

3) Section Number: 10.410 — Adopted Action: Amend

4) Statutory Authority: Implementing Articles I through IX and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IX and 12-13]

5) Effective Date of Rule: February 7, 2014

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

7) Does this rulemaking contain incorporation by reference? No

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

9) Notice of Proposal published in the *Illinois Register*: October 18, 2013; 37 Ill. Reg. 16300

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: Various non-substantive changes were made to Section 10.410(b).

12) Have all 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 rule currently in effect? Yes

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

15) Summary and Purpose of Rulemaking: The Patient Protection and Affordable Care Act, Public Law 111-148, 42 UCS 18001, Section 1413, Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP and Health Subsidy Programs, requires each state to provide an application form that may be filed online, in

person, by mail or by telephone. The requirement is included in 42 CRF 435.907 – Written Application. States began accepting applications under the Affordable Care Act on October 1, 2013. The Food and Nutrition Act of 2008 allows for a state option for accepting telephonic signatures. This rulemaking allows clients to have additional options for applying for the benefits available to them. Clients will now be able to apply by telephone or online, in addition to applying by mail or in person.

A companion amendment is also being adopted in 89 Ill. Adm. Code 121.

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

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield IL 62762

217/785-9772

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

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER a: GENERAL PROGRAM PROVISIONS

PART 10
GENERAL ADMINISTRATIVE PROVISIONS

SUBPART A: APPLICABILITY AND DEFINITIONS

Section
10.101 Incorporation by Reference
10.110 Applicability
10.120 Definitions
10.130 Assistance Programs
10.140 Assistance Program Restrictions

SUBPART B: RIGHTS AND RESPONSIBILITIES

Section
10.210 Rights of Clients
10.220 Nondiscrimination
10.225 Grievance Rights of Clients
10.230 Confidentiality of Case Information
10.235 Case Records
10.250 Reporting Change of Circumstances
10.263 Reporting Child Abuse/Neglect
10.268 Reporting Elder Abuse/Neglect
10.270 Notice to Client
10.280 Right to Appeal
10.281 Continuation of Assistance Pending Appeal
10.282 Time Limit for Filing an Appeal
10.283 Examining Department Records
10.284 Child Care
10.290 Voluntary Repayment of Assistance
10.295 Correction of Underpayments
10.300 Recovery of Assistance
10.310 Estate Claims
10.320 Real Property Liens

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

10.330 Filing and Renewal of Liens
10.340 Foreclosure of Liens
10.350 Release of Liens
10.360 Personal Injury Claims
10.370 Convictions of Fraud – Eligibility
10.380 Single Conviction of Fraud – Administrative Review Board
10.390 Request for Case Transfer

SUBPART C: APPLICATION PROCESS

Section
10.410 Application for Assistance
10.415 Local Office Action on Application for Public Assistance
10.420 Time Limitations on the Disposition of an Application
10.430 Approval of an Application and Initial Authorization of Financial Assistance
10.438 General Assistance Approval Provisions
10.440 Denial of an Application

AUTHORITY: Implementing Articles I through IX and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IX and 12-13].

SOURCE: Emergency rules adopted at 21 Ill. Reg. 9515, effective July 1, 1997, for a maximum of 150 days; adopted at 21 Ill. Reg. 15515, effective November 26, 1997; amended at 22 Ill. Reg. 19816, effective November 1, 1998; amended at 23 Ill. Reg. 6944, effective June 1, 1999; amended at 24 Ill. Reg. 7856, effective May 16, 2000; amended at 24 Ill. Reg. 18153, effective November 30, 2000; amended at 25 Ill. Reg. 7170, effective May 24, 2001; amended at 28 Ill. Reg. 1083, effective December 31, 2003; amended at 28 Ill. Reg. 5650, effective March 22, 2004; amended at 29 Ill. Reg. 8148, effective May 18, 2005; amended at 31 Ill. Reg. 6962, effective April 30, 2007; amended at 31 Ill. Reg. 7638, effective May 15, 2007; amended at 32 Ill. Reg. 4375, effective March 12, 2008; amended at 33 Ill. Reg. 16814, effective November 30, 2009; amended at 33 Ill. Reg. 17345, effective December 14, 2009; amended at 34 Ill. Reg. 10079, effective July 1, 2010; amended at 35 Ill. Reg. 7670, effective April 29, 2011; emergency amendment at 36 Ill. Reg. 10421, effective July 1, 2012, for a maximum of 150 days; emergency amendment at 36 Ill. Reg. 11486, effective July 1, 2012, for a maximum of 150 days; emergency expired November 27, 2012; amended at 37 Ill. Reg. 1865, effective February 4, 2013; amended at 37 Ill. Reg. 3402, effective March 8, 2013; emergency amendment at 37 Ill. Reg. 16838, effective October 1, 2013, for a maximum of 150 days; amended at 38 Ill. Reg. 5375, effective February 7, 2014.

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

SUBPART C: APPLICATION PROCESS

Section 10.410 Application for Assistance

a) An application is a request for cash, medical or SNAP assistance on a Department of Human Services (Department) form or a DHS web application submitted electronically that has been completed to the best of the client's knowledge and ability.

b) The application must contain a name, address, and signature (or signatures). An electronic signature may be accepted if it meets the relevant minimum security requirements established by the Department of Central Management Services, including but not limited to the requirements of 14 Ill. Adm. Code 105.210.~~A web application submitted and received electronically over the Internet does not require a signature to begin the application process for cash and medical assistance, but is required to authorize cash and medical benefits. An electronic signature is used for SNAP applications submitted and received electronically. If the application does not contain a name, address, and signature (or signatures), the local office shall return the application to the sender to obtain the missing information.~~

1) The Department's application for assistance captures the electronic signature on a secure directory and places the electronic signature into a secure database.

2) An electronic signature may be made by an applicant who checks a box and types his or her name; by an applicant who telephonically records his or her voice, constituting a telephonic signature; or by any other symbol that is executed or adopted, using electronic means, by the applicant with the intent to authenticate the record.

3) The application, which includes the electronic signature, is sent to a secure database with auditing capabilities that track the user when the application is modified to ensure the integrity, security and confidentiality of the electronic signature.

c) If the application does not contain a name, address, and signature (or signatures), the local office shall return the application to the sender to obtain the missing information.

1) If a person is homeless, he or she may use the address of a friend or relative, supervised shelter, church, halfway house, or similar facility.

2) If a person is homeless and does not have a permanent address, he or she may use the address of the local office where he or she applied or where his or her case is currently active.

d~~e~~) The application must be signed by the applicant with the following exceptions:

1) When a conservator has been appointed for the applicant, the conservator must sign the application.

2) When the applicant is physically or mentally unable to sign the application, the application may be signed by someone acting responsibly on behalf of the applicant.

3) When application is made on behalf of a child, the child's caretaker must sign the application.

4) When the applicant has appointed an authorized representative with the Department. (An authorized representative is a person authorized by the applicant to act on his or her behalf.)

e~~d~~) Application for medical assistance may be made on behalf of a deceased person. In order for payment to be made by the Department for the funeral and burial expenses of the decedent, the completed application must be received in the local office not more than 30 calendar days after the individual's death, excluding the day on which death occurred, unless delay in receipt of the form occurred through no fault of the individual applying.

f~~e~~) The applicant may be assisted by the Department and by individuals of the applicant's choice in completing the application.

g~~f~~) The date of application shall be the date a completed application is received by

any local office, with the following exceptions:

1) For applications completed by pregnant women and children under age 18 at a disproportionate share hospital or federally-qualified health center, the date the application is signed by the applicant shall be the date of application.

2) When an application is faxed to a local office or a web application is submitted and received over the Internet after 5:00 P.M. on a workday, or on a weekend or holiday, the application date is the next workday following the date the application is received in the local office.

(Source: Amended at 38 Ill. Reg. 5375, effective February 7, 2014)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Supplemental Nutrition Assistance Program (SNAP)

2) Code Citation: 89 Ill. Adm. Code 121

3) Section Number: 121.1 — Adopted Action: Amend

4) Statutory Authority: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13]

5) Effective Date of Rule: February 7, 2014

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, is on file in the Agency's principal office and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: October 18, 2013; 37 Ill. Reg. 16302

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: A non-substantive change was made to Section 121.1(c).

12) Have all 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 rule currently in effect? Yes

14) Are there any rulemakings pending on this Part? Yes

Section Number	Proposed Action	*Illinois Register* Citation
121.57	Amendment	37 Ill. Reg. 15189; September 20, 2013
121.58	Amendment	37 Ill. Reg. 15189; September 20, 2013

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

15) Summary and Purpose of Rulemaking: The Patient Protection and Affordable Care Act, Public Law 111-148, 42 UCS 18001, Section 1413, Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP and Health Subsidy Programs, requires each state to provide an application form that may be filed online, in person, by mail or by telephone. The requirement is included in 42 CRF 435.907 – Written Application. States began accepting applications under the Affordable Care Act on October 1, 2013. The Food and Nutrition Act of 2008 allows for a state option for accepting telephonic signatures. This rulemaking allows clients to have additional options for applying for the benefits available to them. Clients will now be able to apply by telephone or online, in addition to applying by mail or in person.

A companion amendment is also being adopted in 89 Ill. Adm. Code 10.

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

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield IL 62762

217/785-9772

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

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 121
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

SUBPART A: APPLICATION PROCEDURES

Section
121.1 Application for Assistance
121.2 Time Limitations on the Disposition of an Application
121.3 Approval of an Application and Initial Authorization of Assistance
121.4 Denial of an Application
121.5 Client Cooperation
121.6 Emergency Assistance
121.7 Expedited Service
121.8 Express Stamps Application Project
121.10 Interviews

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
121.18 Work Requirement
121.19 Ending a Voluntary Quit Disqualification (Repealed)
121.20 Citizenship
121.21 Residence
121.22 Social Security Numbers
121.23 Work Registration/Participation Requirements
121.24 Individuals Exempt from Work Registration Requirements
121.25 Failure to Comply with Work Provisions
121.26 Periods of Sanction
121.27 Voluntary Job Quit/Reduction in Work Hours
121.28 Good Cause for Voluntary Job Quit/Reduction in Work Hours
121.29 Exemptions from Voluntary Quit/Reduction in Work Hours Rules

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Section
121.30 Unearned Income
121.31 Exempt Unearned Income
121.32 Education Benefits (Repealed)
121.33 Unearned Income In-Kind
121.34 Lump Sum Payments and Income Tax Refunds
121.40 Earned Income
121.41 Budgeting Earned Income
121.50 Exempt Earned Income
121.51 Income from Work/Study/Training Programs
121.52 Earned Income from Roomers or Boarders
121.53 Income From Rental Property
121.54 Earned Income In-Kind
121.55 Sponsors of Aliens
121.57 Assets
121.58 Exempt Assets
121.59 Asset Disregards

SUBPART D: ELIGIBILITY STANDARDS

Section
121.60 Net Monthly Income Eligibility Standards
121.61 Gross Monthly Income Eligibility Standards
121.62 Income Which Must Be Annualized
121.63 Deductions from Monthly Income
121.64 Supplemental Nutrition Assistance Program (SNAP) Benefit Amount

SUBPART E: HOUSEHOLD CONCEPT

Section
121.70 Composition of the Assistance Unit
121.71 Living Arrangement
121.72 Nonhousehold Members
121.73 Ineligible Household Members
121.74 Strikers
121.75 Students
121.76 Categorically Eligible Households

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

Section
121.80 Fraud Disqualification (Renumbered)
121.81 Initiation of Administrative Fraud Hearing (Repealed)
121.82 Definition of Fraud (Renumbered)
121.83 Notification To Applicant Households (Renumbered)
121.84 Disqualification Upon Finding of Fraud (Renumbered)
121.85 Court Imposed Disqualification (Renumbered)
121.90 Monthly Reporting and Retrospective Budgeting (Repealed)
121.91 Monthly Reporting (Repealed)
121.92 Budgeting
121.93 Issuance of Food Stamp Benefits
121.94 Replacement of the EBT Card or SNAP Benefits
121.95 Restoration of Lost Benefits
121.96 Uses for SNAP Benefits
121.97 Supplemental Payments
121.98 Client Training Brochure for the Electronic Benefits Transfer (EBT) System
121.105 State Food Program (Repealed)
121.107 New State Food Program
121.108 Transitional Food Stamp (TFS) Benefits
121.117 Farmers' Market Technology Improvement Program
121.120 Redetermination of Eligibility
121.125 Simplified Reporting Redeterminations
121.130 Residents of Shelters for Battered Women and their Children
121.131 Fleeing Felons and Probation/Parole Violators
121.135 Incorporation By Reference
121.136 Food and Nutrition Act of 2008
121.140 Small Group Living Arrangement Facilities and Drug/Alcoholic Treatment Centers
121.145 Quarterly Reporting (Repealed)

SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

Section
121.150 Definition of Intentional Violations of the Program
121.151 Penalties for Intentional Violations of the Program
121.152 Notification To Applicant Households

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

121.153 Disqualification Upon Finding of Intentional Violation of the Program
121.154 Court Imposed Disqualification

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

Section
121.160 Persons Required to Participate
121.162 Program Requirements
121.163 Vocational Training
121.164 Orientation (Repealed)
121.165 Community Work
121.166 Assessment and Employability Plan (Repealed)
121.167 Counseling/Prevention Services
121.170 Job Search Activity
121.172 Basic Education Activity
121.174 Job Readiness Activity
121.176 Work Experience Activity
121.177 Illinois Works Component (Repealed)
121.178 Job Training Component (Repealed)
121.179 JTPA Employability Services Component (Repealed)
121.180 Grant Diversion Component (Repealed)
121.182 Earnfare Activity
121.184 Sanctions for Non-cooperation with Food Stamp Employment and Training
121.186 Good Cause for Failure to Cooperate
121.188 Supportive Services
121.190 Conciliation
121.200 Types of Claims (Recodified)
121.201 Establishing a Claim for Intentional Violation of the Program (Recodified)
121.202 Establishing a Claim for Unintentional Household Errors and Administrative Errors (Recodified)
121.203 Collecting Claim Against Households (Recodified)
121.204 Failure to Respond to Initial Demand Letter (Recodified)
121.205 Methods of Repayment of Food Stamp Claims (Recodified)
121.206 Determination of Monthly Allotment Reductions (Recodified)
121.207 Failure to Make Payment in Accordance with Repayment Schedule (Recodified)
121.208 Suspension and Termination of Claims (Recodified)

SUBPART I: WORK REQUIREMENT FOR FOOD STAMPS

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Section
121.220 Work Requirement Components (Repealed)
121.221 Meeting the Work Requirement with the Earnfare Component (Repealed)
121.222 Volunteer Community Work Component (Repealed)
121.223 Work Experience Component (Repealed)
121.224 Supportive Service Payments to Meet the Work Requirement (Repealed)
121.225 Meeting the Work Requirement with the Illinois Works Component (Repealed)
121.226 Meeting the Work Requirement with the JTPA Employability Services Component (Repealed)

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13].

SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4,

1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 18, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (by adding Section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690, effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 6804, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; peremptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 8, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; peremptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; peremptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; peremptory amendment at 10 Ill. Reg. 7941, effective May 1, 1986; amended at 10 Ill. Reg. 14692, effective August 29, 1986; peremptory amendment at 10 Ill. Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; peremptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; peremptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; peremptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; peremptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; peremptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 20161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 13619, effective August 14,

1989; peremptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; peremptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 14 Ill. Reg. 16983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 11957, effective August 12, 1991; peremptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 757, effective January 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; peremptory amendment at 16 Ill. Reg. 16345, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 7, 1993, for a maximum of 150 days; peremptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; emergency amendment at 18 Ill. Reg. 2509, effective January 27, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 3427, effective February 28, 1994; amended at 18 Ill. Reg. 8921, effective June 3, 1994; amended at 18 Ill. Reg. 12829, effective August 5, 1994; amended at 18 Ill. Reg. 14103, effective August 26, 1994; amended at 19 Ill. Reg. 5626, effective March 31, 1995; amended at 19 Ill. Reg. 6648, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 12705, effective September 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13595, effective October 1, 1995; amended at 20 Ill. Reg. 1593, effective January 11, 1996; peremptory amendment at 20 Ill. Reg. 2229, effective January 17, 1996; amended at 20 Ill. Reg. 7902, effective June 1, 1996; amended at 20 Ill. Reg. 11935, effective August 14, 1996; emergency amendment at 20 Ill. Reg. 13381, effective October 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 13668, effective October 8, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 3156, effective February 28, 1997; amended at 21 Ill. Reg. 7733, effective June 4, 1997; recodified from the Department of Public Aid to the Department of Human Services at 21 Ill. Reg. 9322; emergency amendment at 22 Ill. Reg. 1954, effective January 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 5502, effective March 4, 1998; amended at 22 Ill. Reg. 7969, effective May 15, 1998; emergency amendment at 22 Ill. Reg. 10660, effective June 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 12167, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16230, effective September 1, 1998; amended at 22 Ill. Reg. 19787, effective October 28, 1998; emergency amendment at 22 Ill. Reg. 19934, effective November 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 20099, effective November 1, 1998; emergency amendment at 23 Ill. Reg. 2601, effective February 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg.

3374, effective March 1, 1999; amended at 23 Ill. Reg. 7285, effective June 18, 1999; emergency amendment at 23 Ill. Reg. 13253, effective October 13, 1999, for a maximum of 150 days; emergency amendment at 24 Ill. Reg. 3871, effective February 24, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 4180, effective March 2, 2000; amended at 24 Ill. Reg. 10198, effective June 27, 2000; amended at 24 Ill. Reg. 15428, effective October 10, 2000; emergency amendment at 24 Ill. Reg. 15468, effective October 1, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 845, effective January 5, 2001; amended at 25 Ill. Reg. 2423, effective January 25, 2001; emergency amendment at 25 Ill. Reg. 2439, effective January 29, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 3707, effective March 1, 2001, for a maximum of 150 days; emergency expired July 28, 2001; amended at 25 Ill. Reg. 7720, effective June 7, 2001; amended at 25 Ill. Reg. 10823, effective August 12, 2001; amended at 25 Ill. Reg. 11856, effective August 31, 2001; emergency amendment at 25 Ill. Reg. 13309, effective October 1, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 151, effective January 1, 2002; amended at 26 Ill. Reg. 2025, effective February 1, 2002; amended at 26 Ill. Reg. 13530, effective September 3, 2002; peremptory amendment at 26 Ill. Reg. 15099, effective October 1, 2002; amended at 26 Ill. Reg. 16484, effective October 25, 2002; amended at 27 Ill. Reg. 2889, effective February 7, 2003; expedited correction at 27 Ill. Reg. 14262, effective February 7, 2003; amended at 27 Ill. Reg. 4583, effective February 28, 2003; amended at 27 Ill. Reg. 7273, effective April 7, 2003; amended at 27 Ill. Reg. 12569, effective July 21, 2003; peremptory amendment at 27 Ill. Reg. 15604, effective October 1, 2003; amended at 27 Ill. Reg. 16108, effective October 6, 2003; amended at 27 Ill. Reg. 18445, effective November 20, 2003; amended at 28 Ill. Reg. 1104, effective December 31, 2003; amended at 28 Ill. Reg. 3857, effective February 13, 2004; amended at 28 Ill. Reg. 10393, effective July 6, 2004; peremptory amendment at 28 Ill. Reg. 13834, effective October 1, 2004; emergency amendment at 28 Ill. Reg. 15323, effective November 10, 2004, for a maximum of 150 days; emergency expired April 8, 2005; amended at 29 Ill. Reg. 2701, effective February 4, 2005; amended at 29 Ill. Reg. 5499, effective April 1, 2005; peremptory amendment at 29 Ill. Reg. 12132, effective July 14, 2005; emergency amendment at 29 Ill. Reg. 16042, effective October 4, 2005, for a maximum of 150 days; emergency expired March 2, 2006; peremptory amendment at 29 Ill. Reg. 16538, effective October 4, 2005; emergency amendment at 30 Ill. Reg. 7804, effective April 6, 2006, for a maximum of 150 days; emergency expired September 2, 2006; amended at 30 Ill. Reg. 11236, effective June 12, 2006; amended at 30 Ill. Reg. 13863, effective August 1, 2006; amended at 30 Ill. Reg. 15681, effective September 12, 2006; peremptory amendment at 30 Ill. Reg. 16470, effective October 1, 2006; amended at 31 Ill. Reg. 6991, effective April 30, 2007; amended at 31 Ill. Reg. 10482, effective July 9, 2007; amended at 31 Ill. Reg. 11318, effective July 23, 2007; peremptory amendment at 31 Ill. Reg. 14372, effective October 1, 2007; amended at 32 Ill. Reg. 2813, effective February 7, 2008; amended at 32 Ill. Reg. 4380, effective March 12, 2008; amended at 32 Ill. Reg. 4813, effective March 18, 2008; amended at 32 Ill. Reg. 9621, effective

June 23, 2008; peremptory amendment at 32 Ill. Reg. 16905, effective October 1, 2008; peremptory amendment to Sections 121.94(c), 121.96(d)(2) and 121.150(b) suspended at 32 Ill. Reg. 18908, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 200, effective February 5, 2009; peremptory amendment repealed by emergency rulemaking at 33 Ill. Reg. 3514, effective February 5, 2009, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 18092, effective November 15, 2008; emergency amendment at 33 Ill. Reg. 4187, effective February 24, 2009, for a maximum of 150 days; emergency expired July 23, 2009; peremptory amendment at 33 Ill. Reg. 5537, effective April 1, 2009; emergency amendment at 33 Ill. Reg. 11322, effective July 20, 2009, for a maximum of 150 days; emergency expired December 16, 2009; amended at 33 Ill. Reg. 12802, effective September 3, 2009; amended at 33 Ill. Reg. 14121, effective September 22, 2009; emergency amendment at 33 Ill. Reg. 14627, effective October 13, 2009, for a maximum of 150 days; emergency expired March 11, 2010; amended at 33 Ill. Reg. 16875, effective November 30, 2009; amended at 33 Ill. Reg. 17350, effective December 14, 2009; amended at 34 Ill. Reg. 4777, effective March 17, 2010; amended at 34 Ill. Reg. 5295, effective April 12, 2010; amended at 34 Ill. Reg. 5823, effective April 19, 2010; emergency amendment at 34 Ill. Reg. 6967, effective May 1, 2010, for a maximum of 150 days; emergency expired September 27, 2010; amended at 34 Ill. Reg. 7265, effective May 10, 2010; amended at 34 Ill. Reg. 7685, effective May 18, 2010; amended at 34 Ill. Reg. 12547, effective August 11, 2010; peremptory amendment at 34 Ill. Reg. 15543, effective October 1, 2010; amended at 35 Ill. Reg. 1042, effective December 28, 2010; amended at 35 Ill. Reg. 7688, effective April 29, 2011; amended at 35 Ill. Reg. 10119, effective June 7, 2011; peremptory amendment at 35 Ill. Reg. 16118, effective October 1, 2011; peremptory amendment at 35 Ill. Reg. 16904, effective October 1, 2011; amended at 35 Ill. Reg. 17120, effective October 5, 2011; amended at 35 Ill. Reg. 18780, effective October 28, 2011; amended at 35 Ill. Reg. 19278, effective November 8, 2011; amended at 35 Ill. Reg. 19778, effective December 5, 2011; peremptory amendment at 36 Ill. Reg. 15148, effective October 1, 2012; emergency amendment at 37 Ill. Reg. 15423, effective September 9, 2013, for a maximum of 150 days; peremptory amendment at 37 Ill. Reg. 16016, effective October 1, 2013; emergency amendment at 37 Ill. Reg. 16845, effective October 1, 2013, for a maximum of 150 days; peremptory amendment at 37 Ill. Reg. 17983, effective November 1, 2013; amended at 38 Ill. Reg. 5382, effective February 7, 2014.

SUBPART A: APPLICATION PROCEDURES

Section 121.1 Application for Assistance

a) An application for Supplemental Nutrition Assistance Program (SNAP) benefits~~food stamps~~ is a written or spoken request containing the client's name,

address and signature. An electronic signature, obtained pursuant to 89 Ill. Adm. Code 10.410, is created when ana web application is submitted and received on the internet or telephonically. An electronic signature may be accepted by the phone interview system for redeterminations.via the Internet or a redetermination is completed using the phone interview system.

b) An application is required for initial certification and subsequent certification. For subsequent certifications see Section 121.120.

c) General Assistance (GA) households in the City of Chicago shall make application to the local GA unit.d)An application for SNAPfood stamp program participation may be made by the head of the household, spouse, another household member or an adult non-household member designated by the household as an authorized representative. When a SNAP food stamp household also files an application for a Public Assistance cash grant under TANF (Temporary Assistance for Needy Families), AABD (Aid to the Aged, Blind or Disabled), or Refugee Programor GA Programs, the grantee for the Public Assistance case shall be the head of the SNAPfood stamp household.

de) If other household members are not available to make application due to employment, health problems, transportation problems, care of a household member, etc., a responsible adult outside the household may be designated as an authorized representative if the following conditions exist:

1) The head of household, spouse or other responsible family members cannot be interviewed;

2) The authorized representative has been designated in writing by the head of the household or the spouse, and is sufficiently aware of relevant household circumstances.

ef) The head of the household shall be held liable for any overissuance which results from erroneous information given on an application by the authorized representative except in instances of participants in drug addiction or alcoholic treatment centers. The center is responsible for misrepresentation or fraud which it knowingly commits in the certification of center residents.

fg) For residents of public or private non-profit drug addiction or alcoholic treatment

centers, or residents of small group living arrangements, the facility will assign an authorized representative to apply in behalf of each resident. This provision is applicable only when the facility has been authorized by the United States Department of Agriculture to accept SNAP benefits~~food stamps~~ in accordance with 7 CFR 278.1 and 278.2(g) (2005, with no later additions or amendments).

g~~h~~) When the eligible members of a household are all unemancipated minors and the only adult is an ineligible alien, the ineligible alien may make application as head of the household in behalf of the eligible minors in the household. (Ineligible aliens applying as head of household will be responsible for any misrepresentation or fraud committed in the certification of the household and will sign the application as head of household, not as authorized representative.)

h~~i~~) Homeless meal providers cannot act as an authorized representative for homeless SNAP~~food stamp~~ applicants or recipients.

(Source: Amended at 38 Ill. Reg. 5382, effective February 7, 2014)

SECRETARY OF STATE

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

1) The Heading of the Part: Lobbyist Registration and Reports

2) Code Citation: 2 Ill. Adm. Code 560

3)

Section Numbers:	Emergency Action:
560.100	Amend
560.310	Amend

4) Statutory Authority: Implementing and authorized by the Lobbyist Registration Act [25 ILCS 170]

5) Effective Date of Repeal: February 7, 2014

6) If this emergency rule is to expire before the end of the 150-day period, please specify the date on which it is to expire:

7) Date Filed with the Index Department: February 7, 2014

8) The Agency maintains a copy of the adopted rule including any reference materials in its principal office in Springfield, Illinois and it is available for public inspection.

9) Reason for Emergency Repeal: The Secretary of State is repealing the emergency rulemaking in response to the Objection issued by the Joint Committee on Administrative Rules at its hearing January 14, 2014.

10) A Complete Description of the Subjects and Issues Involved: The emergency rulemaking was filed to comply with an amendment to the Lobbyist Registration Act [25 ILCS 170] which became effective January 1, 2014. IT programming changes needed to comply with the amendment were incomplete at the time of filing the emergency rule and the Secretary of State wished to have rules in place to comply with the amendment upon its effective date.

11) Are there any proposed rulemakings pending on this Part? Yes

Section Numbers:	Proposed Action:	*Illinois Register* Citation:
560.100	Amendment	37 Ill. Reg. 20628, December 27, 2013
560.310	Amendment	37 Ill. Reg. 20628, December 27, 2013

SECRETARY OF STATE

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

12) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate as defined in Section 3(b) of the State Mandates Act. [30 ILCS 805]

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

Michelle Nijm
Assistant General Counsel
100 W. Randolph, Ste. 5-400
Chicago IL 60601

312/814-7246

The full text of the Emergency Repeal of Emergency Amendments begins on the next page:

SECRETARY OF STATE

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

TITLE 2: GOVERNMENTAL ORGANIZATION
SUBTITLE C: CONSTITUTIONAL OFFICERS
CHAPTER III: SECRETARY OF STATE

PART 560
LOBBYIST REGISTRATION AND REPORTS

SUBPART A: DEFINITIONS

Section
560.100 Definitions
EMERGENCY
560.105 Designated Officials

SUBPART B: LOBBYIST REGISTRATION

Section
560.200 Persons Required to Register
560.205 Designation and Duties of Authorized Agent
560.210 Persons Not Required to Register
560.220 Registration Requirements
560.225 Ethics Training
560.230 Failure to Register (Repealed)

SUBPART C: REPORTING REQUIREMENTS

Section
560.300 Persons Required to File Semi-monthly Reports
560.301 Affirmations
560.305 Time, Place and Manner for Filing Semi-monthly Reports
560.310 Categorizing Expenditures
EMERGENCY
560.315 Allocating Expenditures
560.320 Large Gatherings and Giveaways
560.325 Reporting Expenditures by Participants in Grass Roots Lobbying Events
560.326 Registrant's Duties for Grass Roots Lobbying Events
560.330 Expenditures for Immediate Family Members of Officials
560.340 Travel and Lodging Accommodations for Officials

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

560.345 Members of Legislative or State Study Committees
560.350 Personal and Office Expenses
560.355 Registrant's Duties for Grass Roots Lobbying Events (Repealed)
560.360 Salaries, Fees and Compensation
560.365 Contributions Reported Under the Election Code
560.370 Returned Expenditures/Reimbursement by Official
560.371 Lobbyist Notifications to Officials
560.372 Official's Clarification Notice
560.375 Reports in the Absence of Reportable Expenditures
560.380 Amending Reports
560.385 Termination of Lobbying Activities
560.390 Failure to File Registration Statements and Semi-monthly Reports
560.395 Preservation of Records

SUBPART D: PUBLIC DISCLOSURE

Section
560.400 Requests for Reports
560.402 Location and Business Hours
560.405 Official Forms
560.410 List of Officials
560.420 Fees
560.430 Enforcement

560.APPENDIX A Lobbyist Registration Statements
560.ILLUSTRATION A Form R1: Lobbyist Registration Statement − For Individual/Firm/Partnership/Committee/ Association/Corporation or any Other Organization Employing a Lobbyist on Their Own Behalf (Repealed)
560.ILLUSTRATION B Form R2: Lobbyist Registration Statement − For Individual/Firm/Partnership/Committee/Association/Corporation or any Other Organization Who Performs Lobbying Services on Behalf of Another (Repealed)
560.ILLUSTRATION C Attachment R1/R2: Lobbyist Registration Attachment − For Individual Lobbyist (Repealed)
560.ILLUSTRATION D Form R3: Lobbyist Registration Attachment − For Addition or Deletion of Affiliated Lobbyists (Repealed)
560.ILLUSTRATION E Form R4: Lobbyist Registration Attachment − For

	Addition or Deletion of Affiliated Clients (Repealed)
560.APPENDIX B	Lobbyist Semi-monthly Reports
560.ILLUSTRATION A	Form S1: Lobbyist Semi-monthly Report − Summary of Reportable Expenditures (Repealed)
560.ILLUSTRATION B	Schedule 1A/2A: Lobbyist Expenditure Report − Itemized Expenditures for Travel and Lodging or Meals, Beverages and Entertainment (Repealed)
560.ILLUSTRATION C	Schedule 1B/2B: Lobbyist Expenditure Report − Non-Itemized Expenditures for Travel and Lodging or Meals, Beverages and Entertainment (Repealed)
560.ILLUSTRATION D	Schedule 2C/3C: Lobbyist Expenditure Report − Expenditures for Large Gatherings (Repealed)
560.ILLUSTRATION E	Schedule 3A/4A: Lobbyist Expenditure Report − Itemized Expenditures for Gifts or Honoraria (Repealed)
560.ILLUSTRATION F	Schedule 3B/4B: Lobbyist Expenditure Report − Non-Itemized Expenditures for Gifts and Honoraria (Repealed)
560.ILLUSTRATION G	Schedule GR1: Lobbyist Expenditure Notification − Expenditures Notification in Connection with a Grass Roots Lobbying Event (Repealed)

AUTHORITY: Implementing and authorized by the Lobbyist Registration Act [25 ILCS 170].

SOURCE: Adopted at 18 Ill. Reg. 22532, effective January 1, 1994; amended at 21 Ill. Reg. 405, effective January 1, 1997; emergency amendment at 22 Ill. Reg. 22419, effective December 8, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 5856, effective May 3, 1999; amended at 24 Ill. Reg. 6708, effective April 14, 2000; emergency amendment at 35 Ill. Reg. 2424, effective January 21, 2011, for a maximum of 150 days; emergency expired June 19, 2011; amended at 35 Ill. Reg. 12761, effective July 18, 2011; emergency amendment at 37 Ill. Reg. 20784, effective December 16, 2013, for a maximum of 150 days; emergency repeal of emergency amendment at 38 Ill. Reg. 5395, effective February 7, 2014, for the remainder of the 150 days.

SUBPART A: DEFINITIONS

Section 560.100 Definitions
EMERGENCY

The following definitions shall apply to this Part:

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

"Act" means the Lobbyist Registration Act [25 ILCS 170].

"Administrative action" means the execution or rejection of any rule, regulation, legislative rule, standard, fee, rate, contractual arrangement, purchasing agreement or other delegated legislative or quasi-legislative action to be taken or withheld by any executive agency, department, board or commission of the State. (Section 2(i) of the Act) It shall not include any correspondence or direct lobbying communication to an official providing a response to an official's request.

"Allocation" means the proration of the expenditure made for lobbying an official when the expenditure is made for more than one official, but fewer than 25 officials.

"Authorized Agent" means the person designated by *an entity or lobbyist registered under* the *Act as the person responsible for* the accurate *submission and retention of reports required under* the *Act.* (Section 2(l) of the Act) The authorized agent need not register unless he or she is a lobbyist, as defined in this Section.

"Client" means an individual, firm, partnership, committee, association, corporation or any other organization on whose behalf a lobbyist influences officials with respect to executive, administrative and legislative action. ~~*any person or entity that provides compensation to or employs a lobbyist to lobby State government as provided in the Act.*~~

~~*"Client Registrant" means a client who is required to register under the Act.*~~

"Compensation" means any money, thing of value or financial benefits received or to be received in return for services rendered or to be rendered, for lobbying, as defined in this Section. *Monies paid to* officials *by the State as remuneration for performance or reimbursement of expenses in connection with their constitutional and statutory duties* as officials *shall not constitute compensation.* (Section 2 of the Act)

"Complete Report" means a statement or report to be filed with the Secretary of State Index Department in apparent and substantial conformity with the

requirements of this Part that shall contain the electronic acknowledgement of the authorized agent, the completion of all applicable sections of the statement or report, and the attachment of all appropriate schedules.

"Direct Lobbying Communication" means any activity concerning the direct contact of officials in person or by means of correspondence, telephone or other electronic medium for the purpose of influencing executive, legislative or administrative action. Any correspondence or contact of a routine nature with an official's office, or by a citizen lawfully petitioning a public official pursuant to Section 9 of the Act, shall not be considered direct lobbying communication, unless the communication is made by a hired lobbyist or is in conjunction with a reportable expenditure.

"Due Diligence" means when a lobbyist or authorized agent for any registered entity shows that best efforts have been used to obtain, maintain and submit the information required by the Act. With regard to filing complete reports, the authorized agent will not be deemed to have exercised due diligence unless he or she has access to the expense records of the entity's lobbyists, and has made at least one written request to obtain information required by the Act from the lobbyist that informs the lobbyist that the reporting of that information to the authorized agent is required by law or regulation. This definition should not be construed as a requirement that the authorized agent review the lobbyist's expense records if the lobbyist certifies their accuracy to the authorized agent.

"Employer" means the individual, firm, partnership, committee, association, corporation or any other organization or group of persons by whom a lobbyist is employed, and not the name of the lobbyist's supervisor.

"Executive action" means the proposal, drafting, development, consideration, amendment, adoption, approval, promulgation, issuance, modification, rejection or postponement by a State entity of a rule, regulation, order, decision, determination, contractual arrangement, purchasing agreement or other quasi-legislative or quasi-judicial action or proceeding. (Section 2(g) of the Act) It shall not include any correspondence or communication to an official providing a response to an official's request.

"Expenditure" means a payment, distribution, loan, advance, deposit or gift of money or anything of value, and includes a contract, promise or agreement,

whether or not legally enforceable, to make an expenditure, for the ultimate purpose of influencing executive, legislative or administrative action, other than compensation as defined in this Section. (Section 2(b) of the Act) For the purposes of this Part, "expenditure" refers to a reportable expenditure made on behalf of an official in one of the 6 categories described in Section 6 of the Act and Section 560.310 of this Part.

"File", "Filed" and "Filing" means the submission of a complete report, as defined in this Section, to the Secretary of State Index Department by the close of business on the prescribed filing date. Registration statements, semi-monthly reports, and any other required reports or correspondence shall be completed online, using the Secretary of State Index Department website (http://www.cyberdriveillinois.com/departments/index/home.html) unless otherwise instructed. If the filing deadline falls on a weekend or a holiday, the deadline will be extended to the next business day unless otherwise instructed. The Index Department shall notify any lobbying entity who has failed to submit a complete report and pay proper fees as required by Sections 560.220 and 560.390. An entity that fails to file a complete entity registration statement, semi-monthly report, or other required report or correspondence and/or pay proper fees shall not be considered a registered lobbying entity by the Secretary of State.

"Goodwill" means, for reporting purposes, any expenditure made on behalf of officials that has no direct relation to a specific executive, legislative or administrative action, regardless of whether the lobbyist making the expenditure is reimbursed by his or her employing registered entity or client. Goodwill should be reported as the subject matter when no specific action is discussed.

"Grass Roots Lobbying Communication" means:

correspondence by a representative (a lobbyist or a non-lobbyist) of a registered entity to the general public, or any segment thereof, encouraging correspondence to an official's office in support of, or opposition to, an executive, legislative or administrative action;

correspondence by a member of the general public, or any segment thereof, to an official's office in support of, or opposition to, an executive, legislative or administrative action when such correspondence is a result of a communication described above in this definition. A reportable

expenditure made for or on behalf of an official by a member of the general public as a result of a grass roots lobbying communication shall constitute lobbying activity requiring that individual to register as a lobbyist unless that person reports the expenditure to the registered entity pursuant to Section 560.325.

"Grass Roots Lobbying Event" means:

any organized activity sponsored by a registered entity that is intended to influence the actions of officials by inviting or transporting participants (e.g., members, employees, constituents or the general public) to a specific site on the grounds of, or in the proximity of, public offices or other meeting places where officials are expected to be accessible for grass roots lobbying; or

any event to which officials are invited that is sponsored by a non-lobbyist member or employee of a registered entity, e.g., an on-site inspection of, or reception at, the member's or employee's place of business, or a social gathering at any location. Reportable expenditures incurred as a result of the event shall be reported to the registered entity pursuant to Section 560.325.

"Honorarium" means a payment of money to a member of the General Assembly for an appearance or speech, excluding any actual and necessary travel expenses incurred by the member (and one relative) to the extent that those expenses are paid by any other person. [5 ILCS 420/2-110]

"Influencing" means any communication, action, or reportable expenditure or other means used to promote, support, affect, modify, oppose or delay any executive, legislative or administrative action or to promote goodwill with officials, as defined in this Section. (Section 2(f) of the Act)

"Legislative action" means the development, drafting, introduction, consideration, modification, adoption, rejection, review, enactment or passage or defeat of any bill, amendment, resolution, report, nomination, administrative rule, or other matter by either house of the General Assembly or a committee thereof, or by a legislator. Legislative action also means the action of the Governor in approving or vetoing any bill or portion thereof, and the action of the Governor or any

agency in the development of a proposal for introduction in the legislature. (Section 2(h) of the Act) It shall not include any correspondence or communication to an official providing a response to an official's request.

"Lobby" and "Lobbying" means any communication with an official of the executive or legislative branch of State government as defined in this Section *for the ultimate purpose of influencing* any *executive, legislative or administrative action*. (Section 2(e) of the Act) Lobbying shall not be construed to infringe in any way the right of a citizen to lawfully petition any public official by any means of communication. The following are excluded from the definition of "lobbying":

Any grass roots lobbying communication as defined in this Section;

Any communication by a candidate or political committee, as defined in Article 9 of the Election Code [10 ILCS 5/9], in relation to the candidate's campaign, or other communications by a political party committee registered with the Illinois State Board of Elections or Federal Election Commission;

Any communication by a political committee registered with the Illinois State Board of Elections or Federal Election Commission in connection with a question of public policy referendum to be presented to the electors; and

Any professional or technical assistance or ministerial function (a function in which nothing is left to discretion) as a normal course of business (see Section 560.210(c), (d), and (n) of this Part).

"Lobbyist" means any natural person who undertakes to lobby State government as defined in this Section. (Section 2(j) of the Act)

"Lobbying entity" means any entity that hires, retains, employs or compensates a natural person to lobby State government as provided in this Section. (Section 2(k) of the Act)

"Official" means:

the Governor, Lieutenant Governor, Secretary of State, Attorney General,

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

State Treasurer and State Comptroller and their Chiefs of Staff;

Cabinet members of any elected constitutional officer, including Directors, Assistant Directors and Chief Legal Counsel or General Counsel, and other position titles of comparable ranking that are deemed by their employing Constitutional Officer to be an official under this Part; and

Members of the General Assembly; and

Members of any board, commission, authority, or task force of the State authorized or created by State law or by executive order of the Governor that has authority to make binding recommendations or determinations. (Section 2(c) of the Act) (See Section 560.105 for additional information.)

"Official" shall not be construed to include those individuals possessing power of attorney on behalf of an official.

"Person" means any individual, firm, partnership, committee, association, corporation or any other organization or group of persons. (Section 2(a) of the Act)

"Picture" means an original or photocopied photograph of a lobbyist to be affixed to the lobbyist's registration attachment.

"Professional Services and Technical Skills" shall be limited to advice and analysis directly applying any professional or technical discipline (see Section 560.210(c) and (d) of this Part). Being a professional or technical person does not in itself exempt a person from registering if that person undertakes a direct lobbying communication or makes a reportable expenditure.

"Vendor" means any person who sells or leases commodities, equipment, or real estate to the State of Illinois.

(Source: Emergency amendment repealed by emergency rulemaking at 38 Ill. Reg. 5395, effective February 7, 2014, for the remainder of the 150 days)

SUBPART C: REPORTING REQUIREMENTS

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

Section 560.310 Categorizing Expenditures
EMERGENCY

a) *Expenditures attributable to lobbying officials shall be listed and reported according to the following categories:*

1) *travel and lodging on behalf of others, including, but not limited to, all travel and living accommodations made for or on behalf of State officials during sessions of the General Assembly;*

2) *meals, beverages and other entertainment;*

3) *gifts;*

4) gifts on the basis of personal friendship;

5) *honoraria.* Note: Public Act 89-405 added Section 2-110 of the Governmental Ethics Act [5 ILCS 420/2-110] to prohibit members of the General Assembly from accepting any honorarium. This amendment to the Governmental Ethics Act applies only to members of the General Assembly and contains no similar prohibition with respect to the acceptance of honoraria by other officials;

6) *any other thing or service of value not listed under* subsections (a)(1) through (5), *setting forth a description of the expenditure*. (Section 6(b-2) of the Act)

b) *The report shall itemize each individual expenditure or transaction and shall include the name of the* lobbyist, *the name of the official on whose behalf the expenditure was made, the name of the client on whose behalf the expenditure was made,* if applicable, *the total amount of the expenditure, a description of the expenditure,* the seller, *purveyor* or other provider *to whom the expenditure was made (including the address or location of the expenditure), the date on which the expenditure occurred and the subject matter of the lobbying activity, if any* ~~*For those expenditures made on behalf of a client, if the client is a client registrant, the report shall also include the name and address of the client or clients of the client registrant and the official or officials on whose behalf the expenditures*~~

~~*ultimately were made.*~~ (Section 6(b) of the Act). For purposes of expenditure reporting, the address of an expenditure may be listed as a landmark, if applicable. If there is no subject matter pertaining to the lobbying activity in connection with an expenditure, the term "goodwill" should be reported as the subject matter. Allocation is permitted for determining the itemization threshold (see Section 560.315).

c) Client Information

1) Subject to the qualifications in subsection (c)(2), the semi-monthly report shall include the names and addresses of all the clients who retained the lobbyist or lobbying entity ~~and clients of client registrants required to be identified under Section 6(b) of the Act~~, together with an itemized description for each client of the following:

A) lobbying regarding executive action, including the name of any executive agency lobbied and the subject matter;

B) lobbying regarding any legislative action, including the General Assembly and any other agencies lobbied and the subject matter;

C) lobbying regarding administrative action, including the agency lobbied and the subject matter.

2) Registrants who made no reportable expenditures during a reporting period shall file a report stating that they had no expenditures. If, however, changes in lobbying activities that are reportable under Section 5 of the Act have taken place, a registrant shall amend its registration pursuant to Section 560.220.

(Source: Emergency amendment repealed by emergency rulemaking at 38 Ill. Reg. 5395, effective February 7, 2014, for the remainder of the 150 days)

ILLINOIS DEPARTMENT PUBLIC HEALTH

NOTICE OF RECODIFICATION

1) Heading of the Part: Control of Communicable Diseases Code

2) Code Citation: 77 Ill. Adm. Code 690

3) Date of Index Department Review: February 4, 2014

4) Subparts and Headings Being Recodified:

Subparts	Headings
SUBPART A	REPORTABLE DISEASES AND CONDITIONS
SUBPART B	REPORTING
SUBPART C	DETAILED PROCEDURES FOR THE CONTROL OF COMMUNICABLE DISEASES
SUBPART D	DEFINITIONS
SUBPART E	GENERAL PROCEDURES
SUBPART F	SEXUALLY TRANSMITTED DISEASES
SUBPART G	PROCEDURES FOR WHEN DEATH OCCURS FROM COMMUNICABLE DISEASES
SUBPART H	ISOLATION, QUARANTINE, AND CLOSURE
SUBPART I	REGISTRIES

5) Outline of the Subparts and Headings of the Part As Recodified:

Subparts	Headings
SUBPART A	GENERAL PROVISIONS
SUBPART B	REPORTABLE DISEASES AND CONDITIONS
SUBPART C	REPORTING
SUBPART D	DETAILED PROCEDURES FOR THE CONTROL OF COMMUNICABLE DISEASES
SUBPART E	DEFINITIONS
SUBPART F	GENERAL PROCEDURES
SUBPART G	SEXUALLY TRANSMITTED DISEASES
SUBPART H	PROCEDURES FOR WHEN DEATH OCCURS FROM COMMUNICABLE DISEASES
SUBPART I	ISOLATION, QUARANTINE, AND CLOSURE
SUBPART J	REGISTRIES

ILLINOIS DEPARTMENT PUBLIC HEALTH

NOTICE OF RECODIFICATION

6) Conversion Table Of Present And Recodified Subparts:

Present Subpart	Recodified Subpart
SUBPART A	SUBPART B
SUBPART B	SUBPART C
SUBPART C	SUBPART D
SUBPART D	SUBPART E
SUBPART E	SUBPART F
SUBPART F	SUBPART G
SUBPART G	SUBPART H
SUBPART H	SUBPART I
SUBPART I	SUBPART J

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of February 4, 2014 through February 10, 2014. The Department of Veterans' Affairs and Capital Develop Board rulemakings are scheduled for review at the Committee's February 18, 2014 meeting. The other rulemakings are scheduled for review at the Committee's March 19, 2014 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.

Second Notice Expires	Agency and Rule	Start Of First Notice	JCAR Meeting
3/20/14	Department of Financial and Professional Regulation, Illinois Roofing Industry Licensing Act (68 Ill. Adm. Code 1460)	12/13/13 37 Ill. Reg. 19796	3/19/14
3/20/14	Department of Transportation, Nonscheduled Bus Inspections (92 Ill. Adm. Code 456)	9/13/13 37 Ill. Reg. 14785	3/19/14
3/20/14	Chief Procurement Officer for Capital Development Board, Procurement Practices (Repealer) (44 Ill. Adm. Code 8)	8/2/13 37 Ill. Reg. 12120	2/18/14
3/23/14	Department of Veterans' Affairs, Payment of Viet Nam Veterans Compensation Act (Repealer) (95 Ill. Adm. Code 104)	10/18/13 37 Ill. Reg. 16339	2/18/14
3/23/14	Department of Veterans' Affairs, Rules Governing Educational Opportunities of Children of Deceased Veterans (Repealer) (95 Ill. Adm. Code 101)	10/18/13 37 Ill. Reg. 16325	2/18/14

PROCLAMATIONS

2014-23
Chicago Music Awards Day

WHEREAS, on Sunday, February 23, 2014, Martin's International Culture will present the 33rd Annual Chicago Music Awards; and,

WHEREAS, the Annual Chicago Music Awards is the primary program honoring Illinois entertainers in various music genres such as: Pop, Rock, Gospel, Soul/R&B, Blues, Jazz, Reggae, Country/Western, Latin, Opera, Dance Classical, Polka, Kids and other World Music; and,

WHEREAS, the Chicago Music Awards was founded in 1982 by Ephraim M. Martin, a journalist, entrepreneur and television personality, to honor reggae and other world-beat music, arts and cultures, but has expanded so that all categories of music performed in Illinois can be better appreciated; and,

WHEREAS, at the 33rd Annual Chicago Music Awards, Lifetime Awards will be bestowed on Illinois entertainment legends who have contributed forty years or more to the entertainment industry; and,

WHEREAS, the 33rd Annual Chicago Music Awards Ceremony is dedicated to health awareness and encourages high standards of performance, conduct and professionalism in the music industry; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 23, 2014 as **CHICAGO MUSIC AWARDS DAY** in Illinois, in recognition of the Chicago Music Awards' and its honorees' contributions to music, art, and culture in the Land of Lincoln.

Issued by the Governor January 15, 2014
Filed by the Secretary of State February 10, 2014

2014-24
Martin Luther King, Jr. Day of Service

WHEREAS, Dr. Martin Luther King, Jr. devoted his life to the advancement of civil rights and public service. He believed in a nation of freedom and justice for all, and challenged all citizens to help build a more perfect union and live up to the purpose and potential of America; and,

WHEREAS, Dr. King recognized that everybody can be great because everybody can serve, and during his lifetime encouraged all Americans to serve their neighbors and their communities; and,

WHEREAS, in 1973, the State of Illinois became the first state to make Dr. King's birthday a state holiday. The citizens of Illinois honor Dr. King's legacy each year on the third Monday in January; and,

WHEREAS, legislation creating a federal holiday marking the birthday of Rev. Dr. Martin Luther King, Jr. was signed into law in 1983, and the holiday was first observed in 1986, making 2014 the 28th anniversary of the nationwide observance of the Martin Luther King, Jr. federal holiday; and,

WHEREAS, in 1994, Congress initiated the King Day of Service, a nationwide effort to transform the federal holiday honoring Dr. Martin Luther King, Jr. into a day of community service, grounded in Dr. King's teachings, that helps solve social problems; and,

WHEREAS, this day focuses on bringing people together and breaking down the barriers that have divided us as a nation; and,

WHEREAS, thousands of Illinois residents use Martin Luther King Day as a "day on, not a day off," by spending it performing community service; and,

WHEREAS, each year hundreds of thousands of volunteers in cities and towns across the nation participate in thousands of King Day service projects, in all fifty states, the District of Columbia, Guam, and Puerto Rico; and,

WHEREAS, nonprofit organizations, volunteer managers, AmeriCorps and Senior Corps members across the nation have organized hundreds of projects for volunteers to engage in service honoring the goals of the King Day of Service, and,

WHEREAS, the King Day of Service, which falls on January 20 this year, is an opportune time for the people of Illinois to recognize Dr. King's teachings on advancing equality and opportunity for all by contributing their own time and talents in a day of service; and,

WHEREAS, the King Day of Service is an excellent opportunity to take the first step in making service a regular activity in the lives of Illinois residents and deepen citizenship that comes with serving one's community; and,

WHEREAS, each citizen is encouraged to take part in service that will benefit communities and neighborhoods and provide a fitting memorial to the life of Martin Luther King, Jr.; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim January 20, 2014 as **MARTIN LUTHER KING, JR. DAY OF SERVICE** in Illinois, and urge citizens

throughout Illinois to honor the memory of Dr. King and put his teachings into action by participating in the King Day of Service and finding ways to give back to their communities on this day and throughout the year. To find a volunteer opportunity or to learn more about how to recognize your volunteers, visit the Serve Illinois Commission website at www.Serve.Illinois.gov or call 800-592-9896.

Issued by the Governor January 15, 2014
Filed by the Secretary of State February 10, 2014

2014-25
Perianesthesia Nurse Awareness Week

WHEREAS, there are more than 55,000 perianesthesia registered nurses in the United States whose interests are represented by one of our nation's premier specialty nursing organizations, the American Society of PeriAnesthesia Nurses; and,

WHEREAS, perianesthesia nurses practice in all phases of preanesthesia and postanesthesia care, ambulatory surgery, and pain management; and,

WHEREAS, the depth and breadth of the perianesthesia nursing profession meets the varied and emerging health care needs of the American population in a diversified range of environments; and,

WHEREAS, The American Society of PeriAnesthesia Nurses, as the representative for the perianesthesia nurses of this country, strives to advance nursing practice through education, research and standards; and,

WHEREAS, perianesthesia nursing has been established as essential in the quality of health care and safety of patients in the hospital and ambulatory surgery settings; and,

WHEREAS, the demand for perianesthesia nurses will only increase due to an aging American population, advances in medicine that are prolonging life, and the vast expansion of home health care services; and,

WHEREAS, the inestimable value of the services and care provided by perianesthesia nurses will remain of paramount importance to the American health care system; and,

WHEREAS, along with the American Society of PeriAnesthesia Nurses (ASPAN), the Illinois Society of PeriAnesthesia Nurses (ILSPAN) has declared the week of February 3-9, 2014, as PeriAnesthesia Nurse Awareness Week in recognition of perianesthesia nurses'

steadfast commitment to patient care and the continued advancement of nursing practices; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 3-9, 2014 as **PERIANESTHESIA NURSE AWARENESS WEEK** in Illinois, in recognition of perianesthesia nurses for their indispensable service to the medical profession, and for their commitment to providing quality care and treatment of patients.

Issued by the Governor January 15, 2014
Filed by the Secretary of State February 10, 2014

2014-26
Epilepsy Awareness Month

WHEREAS, epilepsy is one of the most common neurological conditions, estimated to affect over 3 million people in the United States, and more than 50 million worldwide; and,

WHEREAS, epilepsy is a group of disorders of the central nervous system, specifically the brain characterized by recurrent unprovoked seizures; and,

WHEREAS, seizures occur when the normal electrical balance in the brain is lost, causing the brain's nerve cells to misfire, either firing when they shouldn't or not firing when they should. Seizures are the physical effects of these sudden, brief, uncontrolled bursts of abnormal electrical activity; and,

WHEREAS, the type of seizure depends on how many cells fire and which area of the brain is involved. A person that has a seizure may experience an alteration in behavior, consciousness, movement, perception and/or sensation; and,

WHEREAS, one in ten persons will have at least one seizure during his or her lifetime; and,

WHEREAS, the public is often unable to recognize common seizure types, or how to respond with appropriate first aid; and,

WHEREAS, November 2014 is Epilepsy Awareness Month, and was created to bring epilepsy acceptance, awareness and education; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim November 2014 as **EPILEPSY AWARENESS MONTH** in Illinois, in support of the effort to raise awareness of epilepsy.

Issued by the Governor January 16, 2014
Filed by the Secretary of State February 10, 2014

2014-27
Motorcycle Awareness Month

WHEREAS, Illinois is a national leader in motorcycle education and safety; and,

WHEREAS, sharing a roadway is where motorist awareness starts, the Illinois Department of Transportation urges all motor vehicle drivers to expect to see more motorcyclists, riding in traffic in spring and summer months and to respect that they rightfully enjoy the same access to the roads as other traffic; and,

WHEREAS, the Illinois Department of Transportation has been conducting the Illinois Cycle Rider Safety Training Program since 1976; and,

WHEREAS, the program is supported by state motorcycle registration fees and has been responsible for training more than 370,000 cyclists; and,

WHEREAS, better rider education, licensing and public awareness lead to safer motorcycling; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim May 2014 as **MOTORCYCLE AWARENESS MONTH** in Illinois, and encourage all drivers to help keep our roadways safe through proper motorist awareness.

Issued by the Governor January 16, 2014
Filed by the Secretary of State February 10, 2014

2014-28
Illinois Nurse Anesthetists Week

WHEREAS, Certified Registered Nurse Anesthetists (CRNAs), who safely administer more than 33 million anesthetics nationally to patients each year, are essential to America's healthcare system; and,

WHEREAS, CRNAs are the primary providers of anesthesia care in rural Illinois, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, and

trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100% of the rural hospitals; and,

WHEREAS, CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons; U.S. Military, Public Health Services, and Veterans Affairs medical facilities; and,

WHEREAS, Nurse Anesthetists have been the main provider of anesthesia care to U.S. military personnel on the front lines since WWI, including current conflicts in the Middle East. Nurses first provided anesthesia to wounded soldiers during the Civil War; and,

WHEREAS, The Illinois Association of Nurse Anesthetists (IANA) is an organization with 1,600 CRNAs providing Illinois residents safe and cost-effective anesthesia care since 1939; and,

WHEREAS, The Illinois Association of Nurse Anesthetists (IANA) is celebrating their 75th anniversary in 2014; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim the week of January 19-25, 2014 as **ILLINOIS NURSE ANESTHETISTS WEEK**, and urge all citizens to join me in recognizing these outstanding healthcare professionals for their contributions to the quality of life in our state.

Issued by the Governor January 17, 2014
Filed by the Secretary of State February 10, 2014

2014-29
Anti-Cruelty Society Day

WHEREAS, since its founding in 1899, the Anti-Cruelty Society has been committed to caring for animals in the Chicago community; and,

WHEREAS, the mission of the Anti-Cruelty Society is to build a community of caring by helping pets and educating people; and,

WHEREAS, the Anti-Cruelty Society seeks to provide the best quality animal care through collaboration, excellence, professionalism, leadership, communication, and transparency; and,

WHEREAS, the programs offered by the Anti-Cruelty Society include adoptions, a low/no cost spay/neuter clinic, cruelty investigations and rescue, humane education, dog training classes, and short-term accommodations for emergencies; and,

WHEREAS, since 1999, the Anti-Cruelty Society has found loving permanent homes for more than 40,000 pets, spayed or neutered more than 61,000 animals and taught the importance of caring about animals to more than 225,000 school-aged children and community groups; and,

WHEREAS, the Anti-Cruelty Society is a founding member of the Chicago Animal Shelter Alliance (CASA), which was formed in 2002 by a coalition of Chicago shelters to promote the welfare of animals; and,

WHEREAS, the Anti-Cruelty Society will celebrate its 115th anniversary at an event on March 7, 2014; and,

WHEREAS, this is an excellent opportunity to reflect on the Anti-Cruelty Society's accomplishments over the past 115 years and to make plans for its future; and,

WHEREAS, the longevity of the Anti-Cruelty Society is a testament to the hard work and commitment of its employees and volunteers; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 7, 2014, as **ANTI-CRUELTY SOCIETY DAY** in Illinois, in recognition of this organization's 115th anniversary and dedication to serving animals across Chicago and the Land of Lincoln.

Issued by the Governor January 21, 2014
Filed by the Secretary of State February 10, 2014

2014-30
Arts in Education Spring Celebration Months

WHEREAS, the arts are the personification of beauty in the world and help to preserve our cultural heritage; and,

WHEREAS, arts education, which includes dance, drama, music and visual arts, is an essential part of basic instruction for all students, providing them with a balanced education that will aid in developing their full potential; and,

WHEREAS, the Peoria County Regional Office of Education is committed to the establishment and continuation of school programs that provide students with the opportunity to achieve academic excellence; and,

WHEREAS, the Peoria County Regional Office of Education is committed to supporting the development and promotion of fine and applied arts programs; and,

WHEREAS, the Arts in Education Spring Celebration, winner of several awards, is held at the Peoria County Courthouse Plaza and provides a venue for students in grades pre-Kindergarten through 12 to showcase their works and talents; and,

WHEREAS, the 29th annual Arts in Education Spring Celebration will be held April 14 through May 23, 2014; and,

WHEREAS, the State of Illinois supports events such as the Arts In Education Spring Celebration, and commends the students and teachers who work to bring the beauty of art to this great state; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April and May 2014 as **ARTS IN EDUCATION SPRING CELEBRATION MONTHS** in Illinois.

Issued by the Governor January 21, 2014
Filed by the Secretary of State February 10, 2014

2014-31
FFA Week

WHEREAS, agriculture is Illinois' largest and most productive industry, and is vital to the economic success and future prosperity of our state; and,

WHEREAS, agricultural education helps to prepare students for careers in every aspect of agriculture in order to ensure the continued success of this important industry; and,

WHEREAS, agricultural education prepares over 29,000 Illinois students for careers in agribusiness, agriscience, agricultural technology and production agriculture; and,

WHEREAS, Future Farmers of America (FFA) is an integral part of the agricultural education program at the elementary and secondary level; and,

WHEREAS, the National FFA Organization is the nation's largest career and technical student organization; and,

WHEREAS, Illinois Association FFA reaches over 17,000 FFA members and develops their potential for premier leadership, personal growth and career success; and,

WHEREAS, each member of the Illinois Association FFA has demonstrated their interest in the field of agriculture and developed hands-on training in science, business and technology through agricultural education; and,

WHEREAS, the Illinois Association FFA has positively influenced the lives of rural and urban FFA members, parents, educators, and business and community leaders; and,

WHEREAS, more than ninety years of positive FFA influence have benefited over one million Illinois students; and,

WHEREAS, the National FFA Organization has designated a week in February as FFA Week, with the theme "Ignite," which celebrates more than 90 years of FFA traditions while eagerly sparking passion for the organization's future; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 15-22, 2014 as **FFA WEEK** in Illinois, and encourage all citizens to recognize and support agricultural education programs and students in Illinois, and support the ideals of the Illinois Association FFA.

Issued by the Governor January 21, 2014
Filed by the Secretary of State February 10, 2014

2014-32
Fred Korematsu Day

WHEREAS, Fred Korematsu, an important civil rights leader in the Asian American community, devoted his life to eradicating racism and seeking justice. His passion for serving others is admirable and provides a wonderful example to the citizens of the Land of Lincoln; and,

WHEREAS, born on January 30, 1919, Fred Korematsu was the third of four sons to Japanese immigrants who ran a floral nursery business in Oakland, California; and,

WHEREAS, throughout his life, Fred Korematsu faced many forms of discrimination, including being turned away from the U.S. National Guard and U.S. Coast Guard as well as being fired from a welding job due to his Japanese ancestry; and,

WHEREAS, at the age of 23, Fred Korematsu refused to go to the government's incarceration camps for Japanese Americans. After being arrested and convicted of defying the government's order, he pursued legal action, eventually appealing his historically significant case, Korematsu v. United States, all the way to the Supreme Court, and,

WHEREAS, despite losing his case in the Supreme Court, with the help of a pro-bono legal team that included the Asian Law Caucus, Fred Korematsu's case was overturned in 1983 by a federal court in San Francisco, a pivotal moment in civil rights history; and,

WHEREAS, even after his case was overturned, Fred Korematsu remained a committed activist, serving as a member of the National Coalition for Redress and Reparations and speaking at college campuses across the United States; and,

WHEREAS, Fred Korematsu, a trail blazing civil rights leader in the Asian American community, who would also go on to champion the civil rights of Arab Americans and Muslims, is an inspiration to the people of Illinois; and,

WHEREAS, in 1998, Fred Korematsu received the Presidential Medal of Freedom, our nation's highest civilian recognition, from President Bill Clinton; and,

WHEREAS, in Illinois, we seek to recognize civil rights leaders such as Fred Korematsu, a heroic figure whose tenacity and commitment to making the world a better place must never be forgotten; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim January 30, 2014, as **FRED KOREMATSU DAY** in Illinois, in recognition of a remarkable man who lived a life of purpose and action.

Issued by the Governor January 21, 2014
Filed by the Secretary of State February 10, 2014

2014-33
Women in Construction Week

WHEREAS, the National Association of Women in Construction (NAWIC) has distinguished itself as the voice of women in the construction industry since 1953; and,

WHEREAS, since its inception, the NAWIC has formed three different chapters throughout the state of Illinois, whose work with community development and educational programs has touched countless lives in the Land of Lincoln; and,

WHEREAS, based on their core values of "Believe in ourselves as women, persevere with the strength of our convictions, dare to move into new horizons," the NAWIC has remained dedicated to promoting the employment and advancement of women in the construction industry; and,

WHEREAS, the construction community, represented by the NAWIC, has been a driving force in fostering community development through renovation and beautification projects, promotion of skilled trades careers, and a positive vision for the future of Illinois and the entire United States; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 2-8 2014, as **WOMEN IN CONSTRUCTION WEEK** in Illinois and encourage all citizens to raise awareness of the opportunities available for women in construction and to emphasize the growing role of women in the industry.

Issued by the Governor January 21, 2014
Filed by the Secretary of State February 10, 2014

2014-34
Illinois Electric and Telephone Cooperatives Youth Day

WHEREAS, for many years, the Electric and Telephone Cooperatives of Illinois has sponsored a paid tour of Washington, D.C., for approximately 70 outstanding Illinois high school students; and,

WHEREAS, the selection criteria for students to participate includes essay and youth leadership contests that are sponsored by member cooperatives; and,

WHEREAS, students from Illinois, along with nearly 1,500 contest winners from other states, will have an opportunity to witness their federal government in action during the "Youth to Washington" tour taking place on June 13-20, 2014; and,

WHEREAS, in an effort to provide a broader educational experience for students throughout the state, the Electric and Telephone Cooperatives of Illinois will also sponsor a trip to our state capitol on April 2, 2014 for 275 contest finalists; and,

WHEREAS, these hard-working young men and women are the future of our state and country, and deserve to be commended for their achievements and their desire to learn more about their nation's governing bodies; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April 2, 2014 as **ILLINOIS ELECTRIC AND TELEPHONE COOPERATIVES YOUTH DAY** in Illinois, and encourage all citizens to support youth programs that assist those interested in learning about the United States government.

Issued by the Governor January 22, 2014
Filed by the Secretary of State February 10, 2014

2014-35
Men's Health Week

WHEREAS, despite advances in medical technology and research, men continue to live an average of five years less than women, with African-American men having the lowest life expectancy; and,

WHEREAS, recognizing and preventing men's health problems is not just a man's issue. Because of its impact on wives, mothers, daughters, and sisters, men's health is truly a family issue; and,

WHEREAS, educating the public and health care providers about the importance of a healthy lifestyle and early detection of male health problems will help to reduce rates of mortality from disease, improve overall health, and save health care dollars; and,

WHEREAS, men who are educated about the value of preventative health will be more likely to participate in health screenings; and,

WHEREAS, the Men's Health Network collaborated with Congress to develop National Men's Health Week - the week leading up to and including Father's Day - as a special campaign to help educate men and their families about the importance of positive health attitudes and preventative health practices; and,

WHEREAS, Men's Health Week will raise awareness of a broad range of men's health issues, including heart disease, diabetes, prostate, testicular and colon cancer; and,

WHEREAS, all of the citizens of this state are encouraged to recognize the importance of a healthy lifestyle, regular exercise and medical check-ups; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim June 9-15, 2014 as **MEN'S HEALTH WEEK** in Illinois, and encourage all citizens to pursue preventative health practices and early detection efforts.

Issued by the Governor January 22, 2014
Filed by the Secretary of State February 10, 2014

2014-36
Charleston Riot Days

WHEREAS, on March 28, 1864, a riot broke out between Union Soldiers and Illinois civilians, known as the Copperheads, in Charleston Illinois; and,

WHEREAS, the Copperheads, also known as Peace Democrats, were Illinois citizens who opposed the Civil War and had very strong support in Southern Illinois; and,

WHEREAS, the Charleston Riot occurred at the same courthouse where Abraham Lincoln practiced and in the County in which his father and stepmother resided; and,

WHEREAS, the Charleston Riot was the 2nd deadliest riot in a Union controlled state during the Civil War, leading to the death of six Union soldiers of the 54th Illinois Infantry Company C & G and three Illinois civilians; and,

WHEREAS, more than two dozen citizens were arrested and taken into custody by the U.S. Military as a result of an investigation into the cause of the Riot and a Coles County Grand Jury issued indictments against fourteen of the Copperheads including the elected Sheriff of Coles County and his brother; and,

WHEREAS, on November 4th, 1864, President Abraham Lincoln ordered all Copperheads who participated in the Charleston Riot to be released from military custody at Fort Delaware and none of those arrested or indicted were ever convicted for their participation in the Riot; and,

WHEREAS, 2014 marks the 150th anniversary of the Charleston Riot; and,

WHEREAS, the Charleston Riot Committee will be offering entertainment and presenting commemorative events, special presentations, guest speakers, and a reenactment of the Charleston Riot during the weekend of March 28-30, 2014; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 28-30, 2014, as **CHARLESTON RIOT DAYS** in Illinois, in commemoration of the 150th anniversary of the Charleston Riot, and in remembrance of the lives that were lost.

Issued by the Governor January 23, 2014
Filed by the Secretary of State February 10, 2014

2014-37
National Trio Day

WHEREAS, TRIO programs are an integral part of the education of many disadvantaged students in Illinois and throughout the United States; and,

WHEREAS, TRIO programs, which were established by the federal government in 1965, are educational opportunity programs that help students overcome social, cultural and class barriers to higher education by providing information, counseling, academic instruction, tutoring, support and encouragement; and,

WHEREAS, TRIO programs provide outreach services targeted to assist low-income, first-generation college students, and students with disabilities to progress from middle school to post-baccalaureate programs and enhance their prospects of achieving academic excellence; and

WHEREAS, the TRIO program has a consistent record of successfully increasing college retention and graduation rates for eligible students, by preparing these students with the skills, hope and motivation they need to succeed in college; and

WHEREAS, Illinois' many TRIO Projects offer services every year that positively impact students on college campuses and in community agencies across Illinois; and,

WHEREAS, every year on the last Saturday of February, high school and college students, teachers, elected officials, TRIO Program Staff, alumni, and participants celebrate the value of TRIO Programs in our communities throughout the nation; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 22, 2014 as **NATIONAL TRIO DAY** in Illinois, in recognition of the opportunities created by these programs and the positive contributions they make to our educational system.

Issued by the Governor January 23, 2014
Filed by the Secretary of State February 10, 2014

PROCLAMATIONS

2014-38
Save Abandoned Babies Month

WHEREAS, signed into law in August 2001, the Illinois Abandoned Newborn Protection Act allows parents to relinquish a newborn infant to personnel at a local hospital, police station, fire station, or emergency medical facility anonymously and free from prosecution; and,

WHEREAS, signed into law in August 2011, exactly ten years later, an expansion of this law increased infant safe havens to include college or university police stations or any district headquarters of the Illinois State Police; and,

WHEREAS, relinquished babies then may become custody of the state and are placed in a responsible and nurturing safe haven; and,

WHEREAS, the Illinois Abandoned Newborn Protection Act provides a safe alternative to abandonment for Illinois parents who feel they cannot cope with the responsibility of caring for a newborn baby; and,

WHEREAS, it is the hope of the State of Illinois that as awareness of this Act increases, it will stop the abandonment of newborn infants, a practice that has led to healthy babies being found harmed, deceased or in unsafe places; and,

WHEREAS, since the signing of the Illinois Abandoned Newborn Protection Act, numerous newborn babies have been safely relinquished in Illinois pursuant to this Act, but at the same time, newborn infants continue to be unsafely relinquished; and,

WHEREAS, the Illinois Abandoned Newborn Protection Act is a critical statute in the State of Illinois, as it affords the chance of a better life for abandoned newborn babies, but continued public awareness of the Act is necessary to fulfill the goals of protecting all newborn infants and providing parents with a responsible and safe mechanism to relinquish a newborn infant:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April 2014 as **SAVE ABANDONED BABIES MONTH** in Illinois, and encourage all citizens to recognize the importance of protecting abandoned infants and giving them the proper care they deserve.

Issued by the Governor January 23, 2014
Filed by the Secretary of State February 10, 2014

2014-39
Early Hearing Detection and Intervention Day

WHEREAS, approximately 180,000 newborn babies will have their hearing screened in Illinois every year; and,

WHEREAS, in Illinois, nearly 500 children will be identified with hearing loss each year; and,

WHEREAS, the Illinois Hearing Screening for Newborns Act, passed in July of 1999, requires all birthing hospitals in the state to implement universal newborn hearing screening and reporting; and,

WHEREAS, the Universal Newborn Hearing Screening program was established to implement and administer the provisions of the Illinois Hearing Screening for Newborns Act; and,

WHEREAS, the Illinois Department of Human Services, Illinois Department of Public Health, Division of Specialized Care for Children, Bureau of Early Intervention, hospital personnel, healthcare professionals and community-based organizations work together to ensure that the parents of babies who have a hearing loss receive follow-up diagnostic testing and information regarding communication options and other services for their children; and,

WHEREAS, CHOICES for Parents, sponsors of EHDI Day, are celebrating their 14th anniversary of service to parents; and,

WHEREAS, CHOICES for Parents is grateful to its 22 coalition members and its co-sponsor of EHDI Day, the Illinois EHDI Program; and,

WHEREAS, the State of Illinois realizes the importance of universal newborn hearing screening and its impact on the lives of our children as well as their families and communities; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 14, 2014 as **EARLY HEARING DETECTION AND INTERVENTION DAY** in Illinois, in order to create awareness for the importance of early hearing detection and intervention so that babies who have a hearing loss will receive early intervention services in a timely fashion.

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

2014-40
Ice Safety Awareness Month

WHEREAS, the winter season brings with it the joy of winter sports and cold weather activities; and,

WHEREAS, while these activities are enjoyable, not taking the proper safety precautions when recreating around iced-covered bodies of water can cause injury, and even death; and,

WHEREAS, ice safety and education is vital to ensuring the protection of all people during the winter months; and,

WHEREAS, on February 19, 2010, Kadin Baxmeyer was celebrating his 7th birthday with his friend Austin at his home, when the two boys fell through a frozen pond near the family farm; and,

WHEREAS, in an attempt to save the boys, Kadin's mother, Kathy Kohler-Baxmeyer, jumped in to rescue them from the frigid water. All three lost their lives that day; and,

WHEREAS, friends and family of Kadin, Kathy and Austin created a program out of their shared tragedy, Project SKiPeR, in order to teach schoolchildren in Illinois about the dangers of ice-covered bodies of water; and,

WHEREAS, Project SKiPeR's curriculum is based on an ice rescue and awareness program taught by the United States Navy SEALs to sportsmen so they recognize and survive an ice-related danger; and,

WHEREAS, because it is impossible to judge the strength of ice solely by its appearance, age, thickness, temperature, or whether or not it is covered by snow, it is important to understand that there is no such thing as safe ice; and,

WHEREAS, Project SKiPpeR teaches individuals who may find themselves in an ice-related accident to **S**tay calm, **K**ick, **P**ull themselves onto the ice and **R**oll away; and,

WHEREAS, each year many people across the country fall through ice-covered bodies of water and drown, but education significantly helps minimize the risk of ice-related fatalities; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 2014 as **ICE SAFETY AWARENESS MONTH**, and encourage all residents of the Land of Lincoln to "See Ice, Think Twice".

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

PROCLAMATIONS

2014-41
Illinois Poison Prevention Month

WHEREAS, all citizens of Illinois should be made aware of the ever-present dangers posed by potentially poisonous household substances; and,

WHEREAS, children too often have access to over the counter and prescription medications and potentially toxic household products; and,

WHEREAS, over the past 50 years, the nation has been observing National Poison Prevention Week to help prevent accidental poisonings and provide tips for promoting community involvement in poison prevention; and,

WHEREAS, the Illinois Poison Center has been providing timely poison prevention and treatment services to the people of Illinois for over 60 years as the oldest and one of the largest poison centers in the nation; and,

WHEREAS, the Illinois Poison Center is a mainstay in the emergency medical care system of the State of Illinois and is recognized nationally for its contributions to poison treatment and prevention; and,

WHEREAS, 50 percent of the more than 80,000 poisonings reported last year to the Illinois Poison Center involved children under the age of five and could have been prevented; and,

WHEREAS, the Illinois Poison Center manages approximately 90 percent of cases from the general public at home, saving the State of Illinois over $52 million in reduced health care and lost productivity costs; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 2014 as **ILLINOIS POISON PREVENTION MONTH** in Illinois, and encourage all citizens to learn more about the Illinois Poison Center's prevention programs that alert citizens on the continuous problem of accidental poisonings and steps that can be taken to create healthy and safe home, play and work environments.

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

2014-42
Preeclampsia Awareness Day

WHEREAS, preeclampsia is a dangerous condition of pregnancy that can, in its severest form, lead to maternal and/or infant mortality or premature birth with significant health risks for the mother and baby; and,

WHEREAS, more than 350,000 cases of preeclampsia are diagnosed in America every year with 25% classified as severe; and,

WHEREAS, every 6 minutes of every day in America, a pregnant woman and her baby face life threatening consequences because of preeclampsia; and,

WHEREAS, globally, preeclampsia and other hypertensive disorders of pregnancy are a leading cause of maternal and infant illness and death, with conservative estimates claiming that these disorders are responsible for 76,000 maternal and 500,000 infant deaths each year; and,

WHEREAS, public awareness of the symptoms of preeclampsia (spikes in maternal blood pressure, sudden swelling of face, feet, and hands, severe upper abdominal pain, and blurred vision) can help women recognize the condition and seek appropriate medical care; and,

WHEREAS, many citizens of Illinois have joined with the Preeclampsia Foundation to raise public awareness in order to minimize maternal and infant illness and death due to preeclampsia; and,

WHEREAS, along with the Preeclampsia Foundation, the State of Illinois envisions a world where preeclampsia no longer threatens the lives of mothers and babies; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim May 18, 2014, as **PREECLAMPSIA AWARENESS DAY** and applaud the Preeclampsia Foundation's mission to reduce maternal and infant illness and death due to preeclampsia and other hypertensive disorders of pregnancy.

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

2014-43
The Band Chicago Day

WHEREAS, Illinois is a leader in supporting the arts, and music has always been an important component of the artistic fabric of our state; and,

WHEREAS, in 1967, Chicago musicians Walter Parazaider, Terry Kath, Danny Seraphine, Lee Loughnane, James Pankow, Robert Lamm, and Peter Cetera formed the band Chicago; and,

WHEREAS, Chicago would go on to become one of the most successful American rock bands of all time; and,

WHEREAS, Chicago has sold over 100,000,000 records and produced 21 top 10 singles, 11 number 1 singles, and 5 consecutive number 1 albums; and,

WHEREAS, Chicago's Number 1 Albums are Chicago V, Chicago Vl, Chicago Vll, Chicago Vlll, and their Greatest Hits; and,

WHEREAS, Chicago's number 1 singles include "If You Leave Me Now," Hard to Say I'm Sorry," "Look Away," "Beginnings," "Call on Me," and "Here in My Heart"; and,

WHEREAS, Chicago is the first American band to chart Top 40 albums in 5 decades; and,

WHEREAS, 25 of Chicago's 34 albums have been certified platinum; and,

WHEREAS, throughout their illustrious career, Chicago has performed at many important venues including Ford's Theater, the Capitol Building, the JFK Center for Performing Arts, and the Chicago Symphony; and,

WHEREAS, Chicago has won the American Music Awards' Favorite Rock Group (1977 and 1986), been selected as a Billboard Magazine Top 100 artists of all time, and won the People's Choice Award for Favorite Musical Group (1975); and,

WHEREAS, at a ceremony on July 23, 1992, Chicago was honored with a star on the Hollywood Walk of Fame; and,

WHEREAS, despite enjoying tremendous success, Chicago has remained loyal to the people of Illinois and dedicated to serving others; and,

WHEREAS, Chicago will play a free benefit concert on January 29, 2014, at Bloomington's U.S. Cellular Coliseum to raise money for tornado recovery efforts in Illinois, especially for the hard-hit counties of Champaign, Douglas, Fayette, Grundy, Jasper, LaSalle, Massac, Pope, Tazewell, Vermilion, Wabash, Washington, Wayne, Will, and Woodford; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby declare January 29, 2014, as **THE BAND CHICAGO DAY**, in recognition of their impressive success in the music industry, and in support of their efforts to help tornado victims.

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

2014-44
Youth Art Month

WHEREAS, the study of art leads to a fuller, more meaningful life; and,

WHEREAS, art education in the State of Illinois contributes educational benefits to all elementary, middle, and secondary students; and,

WHEREAS, art education teaches students sensitivity to beauty, order, and other expressive qualities; and,

WHEREAS, art education gives students a deeper understanding of multi-cultural values and beliefs, while also bringing to life what is learned in other subjects; and,

WHEREAS, the problem solving skills promoted through art education lead to creative thinking; and,

WHEREAS, our nation's leaders have acknowledged the necessity of including arts experiences in all students' education; and,

WHEREAS, the National Art Education Association, in conjunction with the Illinois Art Education Association, is striving to better the human condition by upgrading visual awareness and the cultural strength of Illinois and the United States as a whole; and,

WHEREAS, the citizens of Illinois have joined the National Art Education Association and the Illinois Art Education Association in supporting the youth of our community in their artistic development; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 2014 as **YOUTH ART MONTH** in Illinois, and urge all citizens to give their full support to quality school art programs for children and youth.

Issued by the Governor January 27, 2014
Filed by the Secretary of State February 10, 2014

2014-45
Illinois Arts Education Week

WHEREAS, the State of Illinois recognizes that arts education, which includes dance, drama, music, and visual arts, is an essential part of basic education for all students, providing them with a balanced education that will aid in developing their full potential; and,

WHEREAS, the arts enrich the lives of children in Illinois and throughout the country by helping them to develop creative ability, self-expression, self-reflection, cognitive skills, discipline, a heightened appreciation of beauty and cross-cultural understanding; and,

WHEREAS, experience in the arts develops insights and abilities central to the experience of life; and,

WHEREAS, the arts are collectively an important repository of our culture; and,

WHEREAS, many national and state professional education associations hold celebrations in the month of March focused on students' participation in the arts; and,

WHEREAS, these celebrations give Illinois schools a unique opportunity to focus on the value of the arts for all students, to foster cross-cultural understanding, to recognize the state's outstanding young artists, to focus on careers in the arts available to Illinois students, and to enhance public support for this important part of their curriculum; and,

WHEREAS, the fine arts are a significant component of students' educational development, teaching them the language and production of the arts, and helping them understand the role of the arts in civilizations, past and present; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 17-23, 2014, as **ILLINOIS ARTS EDUCATION WEEK** and encourage all citizens to celebrate the arts with meaningful student activities and programs that demonstrate learning and understanding in the visual and performing arts.

Issued by the Governor January 28, 2014
Filed by the Secretary of State February 10, 2014

2014-46
DeMolay Month

WHEREAS, DeMolay is an organization dedicated to preparing young men to lead successful, happy and productive lives; and,

WHEREAS, this organization creates opportunities for young men aged 12 to 21 by promoting practical hands on experience that develop civic awareness, personal responsibility and leadership skills which are so vitally needed in society today; and,

WHEREAS, with more than 1,000 chapters worldwide, DeMolay successfully balances their serious mission with a fun, motivational approach that builds important bonds of friendship and camaraderie among participating members; and

WHEREAS, some of the most notable DeMolay alumni include Walt Disney, John Wayne, Walter Cronkite, football Hall-of-Famer Fran Tarkenton, legendary Nebraska football coach Tom Osborne, news anchor David Goodnow and many others; and,

WHEREAS, DeMolay is a socially conscious organization that promotes important values of hard work and dedication to young men across the Land of Lincoln and beyond; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim March 2014 as **DEMOLAY MONTH** in Illinois, and call for public attention to the notable contributions and the wholesome development of young men throughout America.

Issued by the Governor January 29, 2014
Filed by the Secretary of State February 10, 2014

2014-47
Rethink Your Drink Month

WHEREAS, over the past thirty years, the obesity rate in the United States has substantially increased. The prevalence of adult obesity has more than doubled during that time; and,

WHEREAS, for children, the increase in obesity has been even more dramatic, with the obesity rate among children ages 6-11 more than quadrupling over the last four decades; and,

WHEREAS, obese children are at least twice as likely as non-obese children to become obese adults. Research indicates that the likelihood of an obese child becoming an obese adult increases with age; adolescents who are obese have a greater likelihood of being obese in adulthood, as compared to younger children; and,

WHEREAS, the obesity epidemic has led to a dramatic increase in obesity-related health conditions, such as Type 2 diabetes, asthma, and heart disease. These health conditions costs the nation billions of dollars in health care costs and lost productivity; and,

WHEREAS, numerous studies have established a link between obesity and consumption of sweetened beverages such as soft drinks, energy drinks, sweet teas and sports drinks; and,

WHEREAS, sugar-sweetened beverages are the number one source of added sugar in the American diet (46% of added sugars). A study between 1999 and 2004 showed that children and adolescents consumed 10-15% of their daily caloric intake from sweetened beverages; and,

WHEREAS, the American Heart Association recommends that women consume no more than 5 teaspoons of added sugar per day and men consume no more than 9 teaspoons of added sugar per day; and,

WHEREAS, research has found that consumption of sugar-sweetened beverages increases adults' risk of becoming obese by 27% and risk of developing type 2 diabetes by 26%. One study found that the chance of a child becoming obese was increased by 60% with each additional 12-ounce serving of soda each day; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby declare February 2014 as **RETHINK YOUR DRINK MONTH** in Illinois to encourage Illinoisans to limit their sugary beverage consumption and choose healthier options, like water throughout the month.

Issued by the Governor January 29, 2014
Filed by the Secretary of State February 10, 2014

2014-48
Saint Mark's Protestant Episcopal Church Day

WHEREAS, on April 25, 1864, Saint Mark's Day, Saint Mark's Protestant Episcopal Church was founded; and,

WHEREAS, Saint Mark's Protestant Episcopal Church is the oldest Episcopal church on the North Shore and the founding church of Saint Matthew's, Saint Luke's, and Saint Augustine's; and,

WHEREAS, Saint Mark's Protestant Episcopal Church is located in Evanston in the Historic Ridge District; and,

WHEREAS, Saint Mark's Protestant Episcopal Church is listed in the National Register of Historic Places; and,

WHEREAS, under the guidance of The Second Century Committee, in order "to restore what is essential and to add what is good," the restoration of the church's sanctuary began in 1994 and was completed in 2006; and,

WHEREAS, as the church celebrates one hundred and fifty years, its motto is "Being in Place…Growing in Faith…Living from the Center"; and,

WHEREAS, Debra Bullock currently serves as the 18th rector of Saint Mark's Protestant Episcopal Church; and,

WHEREAS, The Reverend Debra Bullock, Rector, and The Reverend Joan Barr Smith, Deacon, serve as the present clergy of Saint Mark's Protestant Episcopal Church; and,

WHEREAS, on Saint Mark's Day in 2014, Saint Mark's Protestant Episcopal Church will be celebrating its Sesquicentennial 150th anniversary; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April 25, 2014, as **SAINT MARK'S PROTESTANT EPISCOPAL CHURCH DAY** in Illinois, and encourage all citizens to join in celebrating the accomplishments and service of this remarkable church.

Issued by the Governor January 29, 2014
Filed by the Secretary of State February 10, 2014

2014-49
Court Reporting and Captioning Week

WHEREAS, as a highly technical career field, stenographic court reporting and captioning require a blend of skills, knowledge, and hard work; and,

WHEREAS, due to its flexibility and significant income potential, court reporting is consistently ranked as one of the top career choices; and,

WHEREAS, stenographic skills are transferable to a variety of careers including court reporting, live-event captioning for the deaf and hard-of-hearing community, and captioning for broadcast and specialized videography; and,

WHEREAS, Forbes has named court reporting as one of the best career options that does not require a four-year degree, and the U.S. Bureau of Labor Statistics reports that the court reporting field is supposed to grow by more than 5 percent in the coming years; and,

WHEREAS, for over 100 years, The National Court Reporters Association has been internationally recognized for promoting excellence among those who capture and convert the spoken word to text; and,

WHEREAS, members of the National Court Reporters Association have contributed greatly to their communities by volunteering their time and professional skills to capture the oral histories of America's disabled veterans; and,

WHEREAS, National Court Reporting and Captioning Week will be marked with educational events nationwide, including a grassroots social media campaign, presentations at high schools across the country about court reporting and captioning career opportunities, and community demonstrations such as producing transcripts of veterans' oral histories; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim February 16-22, 2014 as **COURT REPORTING AND CAPTIONING WEEK** in Illinois, in recognition of the dedication and professionalism of those working in stenographic court reporting and captioning.

Issued by the Governor January 30, 2014
Filed by the Secretary of State February 10, 2014

2014-50
Ependymoma Awareness Day

WHEREAS, ependymoma is a tumor that occurs in the central nervous system of the body. It typically is present in children intracranially and in the spine of adults; and,

WHEREAS, ependymoma accounts for 2–3% of all brain tumors and is the fourth most common brain tumor in children; and,

WHEREAS, adult and pediatric cancers are often thought of and treated separately, however, a collaborative group of scientists and health care providers have joined together to improve the diagnosis, treatment and lives of people living with ependymoma; and,

WHEREAS, these varied practitioners are dedicated to the highest standards of professionalism and maintain these standards through education, and ongoing clinical research and a personal commitment to improve the lives of people living with ependymoma; and,

WHEREAS, people of all ages seek information to improve the diagnosis, treatment, and survival of this tumor which impacts their lives; and,

WHEREAS, it is vital that those with ependymoma, their families, and health care providers understand the full realm of available treatments and seek competent and professional care; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April 10, 2014 to be **EPENDYMOMA AWARENESS DAY** in Illinois, and encourage all citizens to educate themselves on ependymoma and to support improvements in treatment and the quality of life for those afflicted with this disease.

Issued by the Governor January 30, 2014
Filed by the Secretary of State February 10, 2014

2014-51
Illinois Flag Display Act Vincent Petrella

WHEREAS, citizens owe a tremendous debt of gratitude to the men and women of the Illinois Tollway who selflessly work to aid drivers and keep our roadways safe; and,

WHEREAS, every day these men and women face risks and often put their safety on the line to perform their duties; and,

WHEREAS, on January 27, 2014, Illinois Tollway Equipment Operator Laborer Vincent Petrella was tragically taken from us at the age of 39 while helping a driver whose truck was disabled along the Reagan Memorial Tollway in Aurora, Illinois; and,

WHEREAS, Mr. Vincent Petrella was a native of Chicago, Illinois, who joined the Tollway in 2001 and became an equipment operator laborer in 2005, taking on roadway duties that included assisting stranded drivers; and,

WHEREAS, Mr. Vincent Petrella was a respected Tollway employee, a resident of Wheeling and a loving husband, father, son and brother who will always be remembered for the countless lives that he touched; and,

WHEREAS, throughout his career Mr. Vincent Petrella represented the Illinois Tollway admirably; and,

WHEREAS, a funeral service will be held on Tuesday, February 4, 2014, for Mr. Vincent Petrella, who is survived by his wife, two children, his parents, a sister, as well as many other loving relatives and friends; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby order all persons or entities governed by the Illinois Flag Display Act to fly their flags at half-staff from sunrise on Sunday, February 2, 2014 until sunset on Tuesday, February 4, 2014 in honor and remembrance of Mr. Vincent Petrella, whose selfless service, hard work and sacrifice is an inspiration.

Issued by the Governor January 30, 2014
Filed by the Secretary of State February 10, 2014

2014-52
National Black HIV/AIDS Awareness Day

WHEREAS, February 7, 2014, is the 15th annual commemoration and observance of National Black HIV/AIDS Awareness Day; and,

WHEREAS, this observance is a nationwide effort to mobilize black communities to get educated, get tested, get involved and get treated around HIV/AIDS, as it continues to devastate black communities; and,

WHEREAS, Illinois has the sixth highest number of diagnosed HIV infections, and is sixth nationwide in the estimated number of AIDS cases; and,
WHEREAS, there are 34,422 Illinois residents living with HIV, of which 48 percent are black; and,

WHEREAS, African-American men have the highest number of HIV/AIDS cases among all racial/ethnic groups in Illinois, with 34 percent of all reported HIV cases; and,

WHEREAS, African-American women make up 14 percent of all reported HIV/AIDS cases among females in Illinois; and,

WHEREAS, the Illinois Department of Public Health, Center for Minority Health Services, and its community partners are hosting community events throughout the state to recognize this day and its importance to blacks and all concerned citizens; and,

WHEREAS, it is fitting that we join with local, national and international community stakeholders to express our strong support for National Black HIV/AIDS Awareness Day and the initiatives that work to prevent the transmission of HIV and reduce AIDS diagnoses in black communities and provide access to and utilization of HIV/AIDS prevention, treatment and support services to those affected by HIV/AIDS; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby designate February 7, 2014, as **NATIONAL BLACK HIV/AIDS AWARENESS DAY** in Illinois, and encourage all residents to strongly support this day and participate in events planned to commemorate the occasion.

Issued by the Governor January 30, 2014
Filed by the Secretary of State February 10, 2014

2014-53
Fair Housing Month

WHEREAS, April 11, 2014 marks the 46th anniversary of the passage of the U.S. Fair Housing Act, which enunciated a national policy of fair housing and today bars discrimination based on race, color, religion, national origin, sex, familial status or disability; and,

WHEREAS, this year also marks the 35th anniversary of the Illinois Human Rights Act, which bars discrimination in housing based on race, color, religion, national origin, sex (including sexual harassment), physical or mental disability, familial status, age (40 and over), ancestry, marital status, disability, military status, unfavorable discharge from military service, sexual orientation (including gender-related identity), or order of protection status; and,

WHEREAS, acts of housing discrimination and barriers to equal housing opportunity are repugnant to a common sense of decency and fairness; and,

WHEREAS, decent, safe and affordable housing is part of the American dream and a right of all Illinois residents; and,

WHEREAS, economic stability, community health and human relations in all communities of the State of Illinois are improved by diversity and integration; and,

WHEREAS, stable, integrated and balanced residential patterns are threatened by discriminatory acts and unlawful housing practices that result in segregation of residents and opportunities in Illinois communities; and,

WHEREAS, the talents of grassroots and non-profit organizations, housing service providers, housing professionals, financial institutions, elected officials, state agencies and others must be combined to promote and preserve integration, fair housing and equal opportunity; and address the immense challenge of ensuring that every person in Illinois has access to affordable housing; and,

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim April 2014 as **FAIR HOUSING MONTH** in Illinois in commemoration of the signing of the U.S. Fair Housing Act and the Illinois Human Rights Act, as well as to promote integration and equal housing opportunities for everyone and urge all Illinois residents to embrace diversity, recognize the importance of equal opportunity in housing, and to promote appropriate activities by private and public entities intended to provide or advocate for integration and affordable equal housing opportunities for all residents and prospective residents of the State of Illinois.

Issued by the Governor January 31, 2014
Filed by the Secretary of State February 10, 2014

ILLINOIS ADMINISTRATIVE CODE
Issue Index - With Effective Dates

Rules acted upon in Volume 38, Issue 8 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.

PROPOSED RULES

8 - 241 4549
35 - 652 4554
89 - 140 4559
89 - 146 4628
89 - 148 4640
89 - 149 4932
89 - 152 4977
50 - 919 4999
62 - 140 5010
35 - 720 5016
35 - 721 5077
77 - 661 5142
86 - 100 5148
92 - 1030 5163
92 - 1060 5214
92 - 1066 5228

ADOPTED RULES

80 - 310 2/4/2014 5250
89 - 10 2/7/2014 5375
89 - 121 2/7/2014 5382

EMERGENCY RULES

2 - 560 2/7/2014 5395

NOTICE OF CODIFICATION CHANGES

77 - 690 5408

EXECUTIVE ORDERS AND PROCLAMATIONS

14 - 23 1/15/2014 5411
14 - 24 1/15/2014 5411
14 - 25 1/15/2014 5413
14 - 26 1/16/2014 5414
14 - 27 1/16/2014 5415
14 - 28 1/17/2014 5415
14 - 29 1/21/2014 5416
14 - 30 1/21/2014 5417
14 - 31 1/21/2014 5418
14 - 32 1/21/2014 5419
14 - 33 1/21/2014 5420
14 - 34 1/22/2014 5421
14 - 35 1/22/2014 5422

14 - 36	1/23/2014	5423
14 - 37	1/23/2014	5424
14 - 38	1/23/2014	5425
14 - 39	1/27/2014	5425
14 - 40	1/27/2014	5426
14 - 41	1/27/2014	5428
14 - 42	1/27/2014	5428
14 - 43	1/27/2014	5429
14 - 44	1/27/2014	5431
14 - 45	1/28/2014	5431
14 - 46	1/29/2014	5432
14 - 47	1/29/2014	5433
14 - 48	1/29/2014	5434
14 - 49	1/30/2014	5435
14 - 50	1/30/2014	5436
14 - 51	1/30/2014	5437
14 - 52	1/30/2014	5438
14 - 53	1/31/2014	5439

ORDER FORM

☐ Print Version of the Illinois Register ☐ New ☐ Renewal	$290.00 (annually)
☐ Back Issues of the Illinois Register (2012-2013 Only) Volume #_____ Issue#_____Date_____	$ 10.00 (each)
☐ Microfiche sets of the Illinois Register (1977 – 2003) Specify Year(s) _____	$ 200.00 (per set)
☐ Cumulative/Sections Affected Indices (2010) Specify Year(s) _____	$ 5.00 (per set)
(Processing fee for credit cards purchases, if applicable.) $ 2.00 **TOTAL AMOUNT OF ORDER** $ _____	

☐ Check Make Checks Payable To: **Secretary of State**

☐ VISA ☐ Master Card ☐ Discover (There is a $2.00 processing fee for credit card purchases.)

Card #: _____ Expiration Date: _____

Signature: _____

Send Payment To: Secretary of State
Department of Index
Administrative Code Division
111 E. Monroe
Springfield, IL 62756

Fax Order To: (217) 557-8919

Name:		Attention:	ID #:
Address:			
City:		State:	Zip Code:
Phone:	Fax:	E-Mail:	

Published by **JESSE WHITE** • Secretary of State
www.cyberdriveillinois.com