ILLINOIS ADMINISTRATIVE CODE

Issue Index

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NOTICE OF PROPOSED AMENDMENTS

1) **Heading of the Part:** Camping on Department of Natural Resources Properties

2) **Code Citation:** 17 Ill. Adm. Code 130

3) **Section Numbers:** Proposed Action:
   - 130.40 Amendment
   - 130.50 Amendment
   - 130.70 Amendment
   - 130.80 Amendment
   - 130.120 Amendment
   - 130.130 Amendment
   - 130.150 Amendment

4) **Statutory Authority:** Implementing and authorized by Sections 1 and 4(1) and (5) of the State Parks Act [20 ILCS 835/1 and 4(1) and (5)], and by Sections 63a23 and 63a28 of the Civil Administrative Code of Illinois [20 ILCS 805/63a23 and 63a28].

5) **A Complete Description of the Subjects and Issues Involved:** This Part is being amended to provide for camping fee increases, define and designate Premium Campgrounds, allow for fees to be collected at Horseshoe Lake Conservation Area (Alexander County) for use of the Wicker Facility and to extend the number of days a camper may be evicted.

6) **Will this rulemaking contain an automatic repeal date?** No

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

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

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

10) **Statement of Statewide Policy Objective:** This rulemaking does not affect units of local government.

11) **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:

    Jack Price, Legal Counsel
    Department of Natural Resources
    One Natural Resources Way
DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Springfield IL  62702-1271
217/782-1809

12) 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

13) Regulatory Agenda on which this rulemaking was summarized: January 2003

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

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER a: LANDS

PART 130
CAMPING ON DEPARTMENT OF NATURAL RESOURCES PROPERTIES

Section
130.10 Location
130.20 Purpose of Campground
130.30 Classification of Camps by Equipment Used – Definitions
130.40 Definitions
130.50 Registrations
130.60 Permits, Extensions and Time Limits
130.70 Fees and Charges
130.80 Refunds
130.90 Check-in and Check-out Times
130.100 Unoccupied Camps
130.110 Vehicles per Camp (Refer to 17 Ill. Adm. Code 130.30)
130.120 Youth Group (Boy Scouts, Girl Scouts, Explorers, church groups, or others)
130.130 Organization Group Camps (charter organizations, ROTC, private clubs or others)
130.135 Campground Host Program
130.140 Use of Campground
130.150 Violation of Rule
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NOTICE OF PROPOSED AMENDMENTS

AUTHORITY: Implementing and authorized by Sections 1 and 4(1) and (5) of the State Parks Act [20 ILCS 835/1 and 4(1) and (5)], and by Sections 63a23 and 63a28 of the Civil Administrative Code of Illinois [20 ILCS 805/63a23 and 63a28].


Section 130.40 Definitions

Definition of a Camp

a) "Camp" means a single family or group occupying one site that is a designated individual site within a Departmentally managed site, established and maintained for the sole purpose of camping, including the use of tents, trailers or any other type of camping device.

b) A "Single Family" consists of either or both parents and unmarried children. Other family members will be considered as part of the family as long as they occupy the same shelter, but not to exceed a total of 4 adults (18 years of age or older).

c) The "Single Group" consists of unrelated adults (18 years of age or older) with or without children occupying the same shelter. This group would not exceed 4 occupants. (except for Rent-A-Camp sites with an extra large tent which would not exceed 8 occupants and a campground cabin would not exceed 6 occupants).
DEPARTMENT OF NATURAL RESOURCES

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d) A "Camp Shelter" is the portable equipment used by the single family or group for bedding and housing.

e) If more than one camp shelter is required for the single family or group, they shall occupy separate camps. *(Exceptions:* Minor children (under 18) sleeping in sleeping bags or in a tent outside the family shelter are considered occupants sharing the same shelter.) or *A group of no more than 4 occupants may occupy up to 2 or 4 one-man tents on a single campsite.)*

f) In no case will 2 or more tent trailers, travel trailers, self-propelled mobile campers, pick-up campers, or any combination thereof be considered as a single camp.

g) Where campgrounds are laid out in defined sites, not more than one camp will be permitted on a site. Where campgrounds are not laid out in sites, the number of camps will be determined by the capacity of the existing sanitary facilities, parking areas, soil and turf conditions, potential social conflicts between campers due to crowding, and similar factors as determined by Department staff.

h) A "Premium Campground" is a designated camping facility that has a preponderant history of consistently operating at capacity. The following sites are designated as Premium Campgrounds: Chain O'Lakes State Park, Illinois Beach State Park, Kankakee River State Park, Rock Cut State Park, Shabbona Lake State Recreation Area and Starved Rock State Park.

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

Section 130.50 Registrations

a) A permit will be issued and fees collected at the time the camp is established with the camp shelter in place or as soon as possible thereafter (see Sections 130.70 and 130.80). A responsible adult (18 years of age or older) from the camping party must register for the party and thereby acknowledge compliance with the rules and regulations of the park for the party.

b) The camping attendant has the authority to assign sites.

c) Curfew: the provisions of Section 1 of the Child Curfew Act [720 ILCS 555/1]
DEPARTMENT OF NATURAL RESOURCES

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with reference to curfew for persons under the age of 17 years are in effect on Department of Natural Resources' properties.

d) No camping equipment shall be placed on any campground site while that site is occupied by another camping party. A person acquiring a permit must have camp shelter at the time of registration and must occupy the site at that time.

e) In "emergency situations", the camping attendant may designate an area and charge a fee commensurate with facilities provided (see Section 130.70).

f) Reservations will be accepted at selected sites offering reservation service. A $5 non-refundable fee must be submitted for each site reserved. The reservation fee shall be the applicable first night's camping and utility fee in addition to the $5 per campsite non-refundable fee and is required at the time reservation is made for individual campsite reservations. The reservation fee insures that a reserved campsite will be held until 3:00 p.m. of the next day assuring reservation holders of a campsite in the event of late arrival.

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

Section 130.70 Fees and Charges

a) The full amount of the camping fee and, if applicable, the utility fee shall be collected at the time the permit is issued. If checks are taken, they shall be made payable to the Illinois Department of Natural Resources and the site identified. Camping fees vary according to the type of campground and are in accordance with the degree of campground development and type of facilities available effective May 11, 1992 as follows:

1) Spring-Summer Camping (May 1 through September 30)
   
   A) Class AA Sites: Camping fee of $15.12 per night per site, $5.30 utility fee. Sites having availability to showers, electricity, water hookups, sewer hookups, and vehicular access.

   B) Class A Sites: Camping fee of $10.80 per night per site, $5.30 utility fee. Sites having availability to showers, electricity and vehicular access.

   C) Class A Premium Sites: Camping fee of $15 per night per site, $5
DEPARTMENT OF NATURAL RESOURCES

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utility fee. Sites having availability to showers, electricity and vehicular access.

D) Class B-E Sites: Camping fee of $87 per night per site, $53 utility fee. Sites having availability to electricity and vehicular access.

E) Class B-E Premium Sites: Camping fee of $10 per night per site, $5 utility fee. Sites having availability to electricity and vehicular access.

F) Class B-S Sites: Camping fee of $108 per night per site. Sites having availability to showers and vehicular access.

G) Class B-S Premium Sites: Camping fee of $12 per night per site. Sites having availability to showers and vehicular access.

H) Class C Sites: Camping fee of $87 per night per site. Sites having vehicular access or tent camp/primitive sites (walk-in or backpack) having availability to showers.

I) Class D Sites: Camping fee of $6 per night per site. Tent camping or primitive sites with no vehicular access.

J) Youth Group Camping: $24 per person, minimum daily camping fee of $2040.

K) Adult Group Camping: $42 per person, minimum daily camping fee of $4020.

L) Each member of an organized group utilizing facilities furnished at Dixon Springs State Park, Horseshoe Lake State Fish and Wildlife Area (Alexander County) and Pere Marquette State Park shall pay a fee of $4 per night. At Dixon Springs and Horseshoe Lake State Fish and Wildlife Area (Alexander County), a deposit of $40 will be required before confirmation of a reservation. The deposits will be credited to the total camping fee. At Pere Marquette, a deposit of $100 will be required before confirmation of a reservation. The deposits will not be refunded until inspection is made of the facilities after the group departs. If damages warrant, Pere Marquette will have authority to retain this deposit. Fees for day
DEPARTMENT OF NATURAL RESOURCES

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use of the group camps at Dixon Springs, Horseshoe Lake State Fish and Wildlife Area (Alexander County) and Pere Marquette shall be $50 per day.

Rent-A-Camp Tents are Sites will be made available at designated state parks and recreational areas throughout the Department's statewide system. Rent-A-Camp Tent areas will provide, at additional fees of $8 and $12 per night, one large tent (approximately 10' x 13') or one extra large tent (approximately 14' x 14'), respectively (erected), with wood floor, one charcoal grill, one picnic table, one trash barrel, and either 4 sleeping cots per large tent or 8 sleeping cots per extra large tent. The total overnight fee for a Rent-A-Camp Tent will be based on the basic fees of $8 or $12 per night in addition to the class of camping rate on which the Rent-A-Camp site is located fee for the Class A Campsite.

Rent-A-Camp Tent at Class A Sites:
$8 or $12 plus $5 utility fee and $10 camping fee per night per site at all sites having availability to showers, electricity and vehicular access.

Rent-A-Camp Cabin areas will provide, at an additional fee of $25 per night, one 2-bedroom cabin with 2 bunk beds, one full-sized bed, ceiling fans, electric heaters, table with chairs, one charcoal grill, one picnic table, and one trash barrel. The total overnight fee for a Rent-A-Camp Cabin will be based on the basic fee of $25 per night in addition to the fee for the class of the camping site on which the Rent-A-Camp Cabins are located.

Rent-A-Camp Cabins at Class A Sites:
$25 cabin rental plus $5 utility fee and $15 camping fee per night, per site at all sites having availability to showers and vehicular access.

Rent-A-Camp Cabins at Class A Premium Sites:
$25 cabin rental plus $5 utility fee and $15 camping fee per night, per site at all sites having availability to showers and vehicular access.
DEPARTMENT OF NATURAL RESOURCES

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O) A $5 per campsite non-refundable fee must be remitted at those facilities offering reservation services. This fee applies to reservations for group campsites as well as individual site reservations and individual Rent-A-Camp Cabin and individual Rent-A-Camp Tent reservations. In addition to the $5 non-refundable fee, the first night's camping and utility fee is required at the time reservations are made for individual campsite reservations. The Rent-A-Camp Cabin and Tent reservation fee for each cabin/tent will be the applicable first night's cabin/tent rental, camping and utility fees if applicable, in addition to the $5 per campsite non-refundable reservation fee, and is required at the time reservations are made for individual Rent-A-Camp Cabin and Tent campsites.

2) Fall-Winter Camping (October 1 through April 30)

A) As long as buildings, water and electrical service are available, regardless of the date, the regular camping fee will apply.

B) When cold weather requires closing down buildings and shutting off water in any Class A or B Class AA, A or B-S campgrounds, the fee shall be reduced commensurate with the services and facilities available for use.

C) The fee for primitive campsites shall be $6 per site. When a change in facilities is made and a campsite is reclassified, the fee for a site will change automatically.

b) Exceptions: Employees, Concessionaires, and Special Legislation

1) Except for temporary employees of the Department of Natural Resources who qualify and are placed in the campground host program at approved camping sites, employees of the Department of Natural Resources or any other State agency, regardless of their official status, will be required to pay the established camping fee.

2) The concessionaire, manager, or a responsible employee designated by the concessionaire will not be charged the regular camping fee. Rent will be paid at the rate established by the Department or pursuant to the concession lease.
DEPARTMENT OF NATURAL RESOURCES

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3) An Illinois resident age 62 or older, or a person who has a Class 2 disability as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335/4A] or a disabled veteran, or a former prisoner of war as defined in Section 5 of the Department of Veterans Affairs Act [20 ILCS 2805/5], is entitled to the following camping fee provisions, upon qualifying, which will allow the spouse or minor (under 18) children, or minor grandchildren to be included in the camping party. All other members must be registered and pay the regular camping fee for the facilities provided.

A) Illinois residents age 62 or older will be charged one-half the established camping fee on any Monday, Tuesday, Wednesday, or Thursday, at Class AA, A Premium, A, B-E Premium, B-E, B-S Premium, and B-S A and B sites but must pay the entire established camping fee on all sites on any Friday, Saturday or Sunday, and, if at a site with utilities, must pay the entire utility fee for each day of camping. Verification of age may be made by any document required by law to establish proof of age and date of birth and issued by a federal or state governmental agency. No fee on Class C and D sites Monday through Thursday.

B) Illinois residents who have a Class 2 disability and present a current Illinois Disabled Person Identification Card issued by the Secretary of State will be charged one-half the established camping fee for Class AA, A Premium, A, B-E Premium, B-E, B-S Premium and B-S A and B sites on any Monday, Tuesday, Wednesday or Thursday, but must pay the entire established camping fee for any Friday, Saturday or Sunday, and, if at a site with utilities, must pay the entire utility fee for each day of camping. No fee on Class C and D sites.

C) An Illinois resident who is a disabled veteran or former prisoner of war may camp without being charged a camping fee, but if at a site with utilities, must pay the entire utility fee for each day of camping. An individual wishing to qualify for free camping under the provisions stated above must be able to submit the appropriate document issued by the Illinois Department of Veterans' Affairs (see 20 ILCS 2805/5).
Section 130.80 Refunds

a) A refund of camping and utility fees for unused time shall be made, within 7 days after departure, upon the request of the registered camper. No personal check refunds shall be made sooner than 10 days after the check has been deposited to insure clearance. Refunds will be made in the field out of current cash receipts. Refunds for Camper's Permit will be prepared and appropriate copies submitted to accounting.

b) Refund forms must be completed whenever a camper requests a refund for the unused portion of this camping permit.

c) The person requesting the refund must show identification at the time of the refund.

d) The camper's copy of the permit must be surrendered at the time of the refund.

e) Rent-A-Camp reservation fees will not be refunded by the Department.

f) No refunds will be made for reservation fees unless the campground is closed by the Department.

g) The deposit required for organized group camps at Pere Marquette, Dixon Springs, and Horseshoe Lake State Fish and Wildlife Area (Alexander County) will be non-refundable unless notice of cancellation is received at least by 30 days prior to reservation date.

h) There is no refund of the first night's cabin/tent fee or camping and utility fee made as part of a campsite reservation that is canceled less than 3 days prior to the date of arrival.

Section 130.120 Youth Group (Boy Scouts, Girl Scouts, Explorers, church groups, or others)

a) A youth group/organization camp is a group of five or more minors up to 18 years of age who are members of an organization camping with its adult leaders.
DEPARTMENT OF NATURAL RESOURCES
NOTICE OF PROPOSED AMENDMENTS

b) The regular camping fee will be charged on the basis of: $21.00/person, or a minimum of $2040.00 a day.

c) These camps will be placed in an organization campground or special area set aside for such use, rather than in the regular campground.

d) One responsible adult (18 years of age or older) must accompany each group of 15 or fewer campers under the age of 18.

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

Section 130.130 Organization Group Camps (charter organizations, ROTC, private clubs or others)

a) The organized group camping areas are available for camping without showers or electricity. Other forms of camps will be placed in the appropriate sites on an individual and equal basis with other campers. An organized group camp is a group of 10 or more adults (18 years of age or older) with or without children.

b) The regular camping fee will be charged on the basis of: $42/person; or a minimum of $4020 a day.

c) If the organized group camping area is unavailable, the organization will be accommodated only as individual campers and will use the regular campgrounds on an equal basis with other campers. The camping fee and utility fee applicable to the campsite classification will be charged for each campsite used by the group.

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

Section 130.150 Violation of Rule

a) For violation of these rules and regulations, a camper is subject to eviction. The camper at the demand of the Department, shall remove all equipment and personal property.

b) The Department may refuse to permit a person to re-enter the eviction site/park for a period of up to 36590 days from such eviction.

c) No refunds will be granted in such cases.
d) Any person who violates any provision of this Part shall be guilty of a Class B Misdemeanor.

(Source: Amended at 28 Ill. Reg. ______, effective ____________)
DEPARTMENT OF PUBLIC HEALTH

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1) **Heading of the Part**: Illinois Home Health Agency Code

2) **Code Citation**: 77 Ill. Adm. Code 245

3) **Section Numbers**: Proposed Action:
   - 245.20 Amendment
   - 245.30 Amendment

4) **Statutory Authority**: Home Health Agency Licensing Act [210 LCS 55]

5) **A complete description of the subjects and issues**: The rules are being amended to add two new requirements for personnel policies. Before hiring an individual in a position that requires a State license, the agency will be required to contact the Illinois Department of Professional Regulation to verify that the individual’s license is active. Agencies will also be required to check the status of all employee prospects who have direct care responsibilities with the nurse aide registry.

   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) **Will this rulemaking replace an emergency rulemaking currently in effect?** No

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

8) **Does this rulemaking contain any incorporations by reference?** No

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

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<tr>
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<tr>
<td>245.72</td>
<td>Amendment</td>
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10) **Statement of Statewide Policy Objective**: This rulemaking does not create or expand a State Mandate.

11) **Time, place, and manner in which interested persons may comment on this rulemaking**: Interested persons may present their comments concerning this rulemaking within 45 days after this issue of the *Illinois Register* to:
DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 West Jefferson St., 5th Floor
Springfield, Illinois 62761
217/782-2043
e-mail: rules@idph.state.il.us

These rules may have an impact on small businesses. In accordance with Sections 1-75 and 5-30 of the Illinois Administrative Procedure Act, any small business may present its comments in writing to Susan Meister at the above address.

Any small business (as defined in Section 1-75 of the Illinois Administrative Procedure Act) commenting on these rules shall indicate its status as such, in writing, in its comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of small businesses, small municipalities and not-for-profit corporations affected: Home health agencies

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

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 2001

The full text of the Proposed Amendments begins on the next page:
DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section
245.10 Purpose
245.20 Definitions
245.25 Incorporated and Referenced Materials

SUBPART B: OPERATIONAL REQUIREMENTS

Section
245.30 Organization and Administration
245.40 Staffing and Staff Responsibilities
245.50 Services
245.60 Annual Financial Statement
245.70 Home Health Aide Training
245.72 Health Care Worker Background Check

SUBPART C: LICENSURE PROCEDURES

Section
245.80 Licensure Required
245.90 License Application
245.100 Provisional License
245.110 Inspections and Investigations
245.120 Violations
245.130 Adverse Licensure Actions
245.140 Penalties and Fines
245.150 Hearings

AUTHORITY: Implementing and authorized by the Home Health Agency Licensing Act [210 ILCS 55].

SUBPART A: GENERAL PROVISIONS

Section 245.20 Definitions

Act – the Home Health Agency Licensing Act [210 ILCS 55].

Administrator – any one of the following:

a physician;

a registered nurse;

an individual with at least one year of supervisory or administrative experience in home health care or in related health provider programs; or

an individual who meets the requirements for Public Health Administrator as contained in 77 Ill. Adm. Code 600.300 of the Certified Local Health Department Code (77 Ill. Adm. Code 600) as promulgated by the Department.

Agency – a Home Health Agency, unless otherwise designated.

Audiologist – a person who has received a license to practice audiology pursuant to the Illinois Speech-Language Pathology and Audiology Practice Act [225 ILCS 110].

Branch Office – a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.
Bylaws or Equivalent – a set of rules adopted by a home health agency for governing the agency's operation.

Clinical Note – a dated, written notation by a member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and/or drug given, the patient's reaction and any changes in physical or emotional condition.

Clinical Record – an accurate account of services provided for each patient and maintained by the agency in accordance with accepted professional standards.

Department – The Department of Public Health of the State of Illinois. (Section 2.01 of the Act)

Director – the Director of Public Health of the State of Illinois, or his designee. (Section 2.02 of the Act)

Discharge Summary – the written report of services rendered, goals achieved and final disposition at the time of discharge from service.

Employee Prospect – a person or persons to whom an agency expects to extend an offer of employment.

Geographic Service Area – the area from which patients are drawn. This area is to be clearly defined by readily recognizable boundaries.

Home Health Agency – a public agency or private organization which provides skilled nursing services and at least one other home health service as defined in this Part. (Section 2.04 of the Act)

Home Health Aide – a person who provides personal care and emotional comfort to assist the patient toward independent living in a safe environment. A person may not be employed as a home health aide unless he/she meets the requirements of Section 245.70 of this Part.

Home Health Services – services provided to a person at his residence according to a plan of treatment for illness or infirmity prescribed by a physician or podiatrist. Such services include part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech
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therapy, medical social services or services provided by a home health aide. (Section 2.05 of the Act)

Licensed Practical Nurse – a person currently licensed as a licensed practical nurse under the Illinois Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65].

Medical Social Worker – a person who is a licensed social worker or a licensed clinical social worker under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] and has one year of social work experience in a health care setting.

Occupational Therapist – a person who is licensed as an occupational therapist under the Illinois Occupational Therapy Practice Act [225 ILCS 75] and meets one or more of the following requirements:

is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, or

is eligible for the National Registration Examination of the American Occupational Therapy Association, or

has two years of appropriate experience as an occupational therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such examinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapist after December 31, 1977.

Occupational Therapy Assistant – a person who is licensed as an occupational therapy assistant under the Illinois Occupational Therapy Practice Act and meets one or more of the following requirements:

meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association, or

has two years of appropriate experience as an occupational therapy assistant and has achieved a satisfactory grade on a proficiency
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examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

Part Time or Intermittent Care – home health services given to a patient at least once every 60 days or as frequently as a few hours a day, several times per week.

Patient – a person who is under treatment or care for illness, disease, injury or conditions appropriately responsive to home health services to maintain health or prevent illness.

Patient Care Plan – a coordinated and combined care plan prepared by and in collaboration with each discipline providing service to the patient, to the patient's family, or to both.

Person – any individual, firm, partnership, corporation, company, association or any other legal entity. (Section 2.03 of the Act)

Physical Therapist – a person who is licensed as a physical therapist under the Illinois Physical Therapy Act [225 ILCS 90] and who meets the qualifications for a physical therapist under the Federal Conditions of Participation for Home Health Agencies established by the Health Care Financing Administration (42 CFR 484.1 through 484.40).

Physical Therapist Assistant – a person who is licensed as a physical therapist assistant under the Illinois Physical Therapy Act and who meets the qualifications for a physical therapist assistant under the Federal Conditions of Participation for Home Health Agencies established by the Health Care Financing Administration (42 CFR 484.1 through 484.40).

Physician – Any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60]. For a patient who has received medical care in another state, or has moved from another state, and who has not secured the services of a physician licensed in Illinois, an individual who holds an active license to practice medicine in another state will be considered the physician for the patient during this emergency (as determined by the physician) as provided in Section 3 of the Medical Practice Act of 1987. Such an emergency may not extend more than six months in any case.
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Plan of Treatment – a plan based on the patient's diagnosis and the assessment of the patient's immediate and long-range needs and resources. The plan of treatment is established in consultation with the home health services team, which includes the attending physician or podiatrist, pertinent members of the agency staff, the patient and members of the family.

Podiatrist – a person who is licensed to practice under the Podiatric Medical Practice Act of 1987 [225 ILCS 100].

Professional Advisory Group – a group composed of at least one practicing physician, one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines that are participating in the provision of home health services. It is highly recommended that a consumer be a member of the group. At least one member of the group is neither an owner nor an employee of the agency.

Progress Notes – a dated, written notation by a member of the health team, summarizing facts about care and the patient's response during a given period of time.

Purchase of Services/Contractual – the provision of services through a written agreement with other providers of services.

Registered Nurse – a person who is currently licensed as a registered nurse under the Illinois Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65].

Social Work Assistant – a person who has a baccalaureate degree in social work, psychology, sociology, or other field related to social work and has had at least one year of social work experience in a health care setting; or has two years of appropriate experience as a social work assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualifications as a social work assistant after December 31, 1977.

Speech-Language Pathologist – a person who is licensed as a speech-language pathologist under the Illinois Speech-Language Pathology and Audiology Practice Act [225 ILCS 110].
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Student – an individual who is enrolled in an educational institution and who is receiving training in a health-related profession.

Subdivision – a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the federal conditions of participation for home health agencies. A subdivision that has branches is regarded as a parent agency.

Substantial compliance or substantially meets – meeting requirements except for variance from the strict and literal performance, which results in unimportant omissions or defects given the particular circumstances involved.

Subunit – a semi-autonomous organization, which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the agency is judged incapable of sharing administration, supervision and services.

Summary Report – a compilation of the pertinent factors from the clinical notes and progress notes regarding a patient, which is submitted to the patient's physician or podiatrist.

Supervision – authoritative procedural guidance by a qualified person of the appropriate discipline.

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

SUBPART B: OPERATIONAL REQUIREMENTS

Section 245.30 Organization and Administration

a) Governing Body. The home health agency shall have a governing body or a clearly defined body having legal authority and responsibility for the conduct of the home health agency. Where the governing body of a large organization is functionally remote from the operation of the home health agency, the Department may approve the designation of an intermediate level "governing body". For the purposes of this Section the governing body shall:

1) Have bylaws or the equivalent, which shall be reviewed annually and be revised as needed. They shall be made available to all members of the governing body and of the professional advisory group. The bylaws or the
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equivalent shall specify the objectives of the agency.

2) Appoint members of the professional advisory group.

3) Employ a qualified administrator.

4) Adopt and revise, as needed, policies and procedures for the operation and administration of the agency.

5) Meet to review the operation of the agency.

6) Keep minutes of all meetings.

7) Provide and maintain an office facility adequately equipped for efficient work and that provides a safe working environment in compliance with local ordinances and fire regulations.

b) Professional Advisory Group

1) The professional advisory group shall assist in developing and recommending policies and procedures for administration and home health services provided by the agency. These policies and procedures shall be in accordance with the scope of services offered by the agency and based on the home health needs of the patient and the area being served. Policies and procedures shall be reviewed annually or more frequently as needed to determine their adequacy and suitability. Recommendations for any improvements are made to the Governing Body. These policies and procedures shall include but not be limited to:

A) Administration and supervision of the agency and the home health services it provides.

B) Criteria for the acceptance, non-acceptance and discharge of patients.

C) Home health services.

D) Medical supervision and plans of treatment.

E) Patient care plans.
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F) Clinical records.

G) Personnel data.

H) Evaluation.

I) Coordination of services.

2) The group shall keep minutes of its meetings and meet as often as necessary to carry out its purposes.

c) Administration

1) The home health agency shall have written administrative policies and procedures to ensure the provision of safe and adequate care of the patient.

2) The home health agency shall show evidence of liability insurance.

d) Agency Supervision

1) The home health agency shall designate a person with one of the following sets of qualifications to supervise the provision of home health services:

A) A physician;

B) A registered nurse who:

i) has completed a baccalaureate degree program approved by the National League for Nursing; and

ii) has at least one year of nursing experience.

C) registered nurse who does not have a baccalaureate degree, but who has at least three years of nursing experience, which meets the following requirements:

i) At least two years of such nursing experience must have been in either: a home health agency; a community health
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program that included care of the sick; or a generalized family-centered nursing program in a community health agency.

ii) At least two years of the three years nursing experience must have been obtained within five years prior to current employment with the home health agency.

2) The agency supervisor shall be available at all times during operating hours of the agency and participate in all activities relevant to the provision of home health services.

3) Any person employed as an agency supervisor prior to July 1, 1983, may continue to serve in that capacity at that agency only without meeting the qualifications for agency supervisor that were in effect prior to October 1, 1983.

4) One person may hold the positions of both administrator and agency supervisor, if that person meets the requirements of both positions.

e) Supervising Nurse

1) The skilled nursing service of a home health agency shall be under the supervision of a full-time registered nurse.

2) The supervising nurse shall be responsible for:

A) The overall supervision of all registered nurses, licensed practical nurses and home health aides.

B) The assurance that the professional standards of community nursing practice are maintained by all nurses providing care.

C) Maintaining and adhering to agency procedure and patient care policy manuals.

D) Participation in the establishment of service policies and procedures.

E) Participation in the selection of nursing personnel and the
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evaluation of nursing personnel.

F) Coordination of patient care services.

G) Keeping and maintaining records of case assignments and case management.

H) Preparation and maintenance of scheduling of cases to be brought to the clinical record review committee.

I) The conduct of selective program evaluations to improve deficient services and the development and implementation of plans of correction.

f) Personnel Policies

1) Personnel policies applicable and available to all full- and part-time employees shall include but not be limited to the following:

A) Wage scales, fringe benefits, hours of work and leave time.

B) Requirements for an initial health evaluation of each new employee who has contact with patients, including a physical examination and any other components as specified by the governing body.

C) Orientation to the home health agency and appropriate continuing education.

D) Job descriptions for all positions utilized by the agency.

E) Annual performance evaluation for all employees.

F) Compliance with all applicable requirements of the Civil Rights Act of 1964.

G) Provision for confidentiality of personnel records.

H) Employee health policies that require employees to report health symptoms and exposure to any communicable or infectious disease
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and that specify conditions under which employees are to be removed from patient contact and conditions under which employees may resume patient contact.

2) Prior to employing any individual in a position that requires a State professional license, the home health agency shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the verification of the individual's license shall be placed in the individual's personnel file.

3) The home health agency shall check the status of employee prospects who have direct patient care responsibilities with the Nurse Aide Registry prior to hiring.

4) Personnel records for all employees shall include the name and address of the employee, social security number, date of birth, name and address of next of kin, evidence of qualifications (including any current licensure, registration, or certification that is required by state or federal law for the functions performed), dates of employment and separation from the agency and the reason for separation.

5) Home health agencies that provide other home health services under arrangement through a contractual purchase of services shall ensure that these services are provided by qualified personnel, who hold any current licensure, registration, or certification that is required by state or federal law for the functions performed, under the supervision of the agency.

(Source: Amended at 28 Ill. Reg. ______, effective ____________ )
NOTICE OF PROPOSED AMENDMENT

1) **Heading of the Part:** Retailers' Occupation Tax

2) **Code Citation:** 86 Ill. Adm. Code 130

3) **Section Numbers:** Proposed Action:
   - 130.552 New Section

4) **Statutory Authority:** P.A. 93-0022

5) **A Complete Description of the Subjects and Issues Involved:** This proposed rulemaking implements the requirements of P.A. 93-0022 that require purchases of alcoholic liquor to be reported to the Department by liquor retailers and liquor wholesalers beginning on October 1, 2003. This proposed rulemaking requires liquor stores, taverns, and restaurants that serve alcoholic beverages to report liquor purchases for each month on their ST-1, Sales and Use Tax Return, and to file such returns using the Department’s TeleFile system. Such reporting requirements do not apply to taxpayers that make quarter-monthly sales tax payments or wholesalers or manufacturers of alcoholic liquors. This proposed rulemaking also requires wholesalers and manufacturers of alcoholic liquor to electronically file a statement with the Department on the 10th day of each month showing the total amount of gross receipts from alcoholic liquors sold or distributed to purchasers in the preceding month. As an alternative, the rules allow such wholesalers and manufacturers of alcoholic liquor to electronically file the statement in conjunction with their electronically filed Form RL-26, Liquor Revenue Return, no later than the 15th day of the month. Wholesalers and manufacturers of alcoholic liquor are also required to provide liquor stores, taverns, and restaurants with a copy of such statement by the 10th day of each month. However, the rules allow such wholesalers and manufacturers of alcoholic liquor to provide a cumulative total of sales to each retailer on the invoices provided to each retailer in lieu of providing the statement to those retailers.

6) **Will this proposed amendment replace an emergency amendment currently in effect?** Yes

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

8) **Does this proposed amendment contain incorporations by reference?** No

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

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130.120 Amendment 27 Ill. Reg. 73, 01/03/03
130.605 Amendment 27 Ill. Reg. 73, 01/03/03
130.1951 Amendment 27 Ill. Reg. 73, 01/03/03
130.2140 Amendment 27 Ill. Reg. 73, 01/03/03

10) Statement of Statewide Policy Objectives: This rulemaking does not create a State mandate, nor does it modify any existing State mandates.

11) 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:

Terry D. Charlton
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois  62794
Phone: (217) 782-2844

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Certain liquor stores, taverns, restaurants that sell liquor for on-premises consumption, liquor distributors, and manufacturers of alcoholic liquors

B) Reporting, bookkeeping or other procedures required for compliance: Certain liquor stores, taverns, restaurants that sell liquor for on-premises consumption are required to report on their sales tax returns the cost of all alcoholic liquor purchased in the previous month. Liquor distributors and manufacturers of alcoholic liquors are required to electronically file a monthly statement with the Department listing all sales of alcoholic liquor and to provide a statement to each retailer that has purchased alcoholic liquor of the amount of alcoholic liquor sold by that distributor to that retailer in the previous month.

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 2003
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The full text of the proposed amendment is identical to the text of the emergency amendment on page 18911 of this issue of the Illinois Register.
DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

1) **Heading of the Part**: Liquor Control Act

2) **Code Citation**: 86 Ill. Adm. Code 420

3) **Section Numbers**: 420.80

4) **Proposed Action**: Amendment

5) **Statutory Authority**: P.A. 93-0022

6) **A Complete Description of the Subjects and Issues Involved**: This rulemaking implements the requirements of P.A. 93-0022 that increased the discount that liquor tax filers are given for voluntarily filing their liquor tax returns and making payment through electronic funds transfer. These discounts increased from the current discount of 1.75% or $1,250 per return whichever is less to, beginning October 1, 2003 through September 30, 2004, a discount of 2% or $3,000 per return whichever is less, and beginning October 1, 2004, a discount of 2% or $2,000 per return whichever is less.

7) **Will this proposed amendment replace an emergency amendment currently in effect?** No

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

9) **Does this amendment contain incorporations by reference?** No

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

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:

    Terry D. Charlton
    Associate Counsel
    Illinois Department of Revenue
    Legal Services Office
    101 West Jefferson
    Springfield, Illinois  62794
    Phone: (217) 782-2844
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12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Liquor distributors and manufacturers paying liquor tax to the State.

B) Reporting, bookkeeping or other procedures required for compliance: Discounts are available for those taxpayers who voluntarily choose to file their returns and pay their tax liability to the Department by electronic means.

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent regulatory agendas because: it was unanticipated at the time.

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

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 420
LIQUOR CONTROL ACT

Section 420.10 Gallonage Taxes
420.20 Claims to Recover Erroneously Paid Tax
420.30 Shipments of Alcoholic Liquors Out of Illinois
420.40 Non-Beverage Alcoholic Preparations and Compounds
420.50 Non-Beverage Users of Alcoholic Liquors
420.60 Act Does Not Apply
420.70 Tax Provisions of Act Do Not Apply
420.80 Monthly Return
420.90 Books and Records
420.100 Carriers
420.110 Sales to Governmental Bodies
420.120 Warehousing of Liquors
420.130 Non-Beverage User's Books and Records
420.140 Tax-Free Sales of Alcoholic Liquor for Use Aboard Ships Operating in Foreign Commerce Outside the Continental Limits of the United States
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NOTICE OF PROPOSED AMENDMENT

AUTHORITY: Implementing and authorized by Article VIII of the Liquor Control Act of 1934 [235 ILCS 5/Art. VIII].


Section 420.80 Monthly Return

a) Requirement for Filing:

1) Each manufacturer and importing distributor of alcoholic liquor must file a return on the form approved and provided by the Department between the 1st and 15th day of each calendar month, covering transactions in alcoholic liquors during the preceding calendar month. Payment of the tax in the amount disclosed by the return shall accompany the return.

A) Voluntary Electronic Filing and Payment of Taxes. Beginning January 1, 2003, taxpayers may elect to file returns electronically under the provisions of 86 Ill. Adm. Code 760. A taxpayer that elects to electronically file a return and accompanying schedules must also make payment through Electronic Funds Transfer as provided in 86 Ill. Adm. Code 750. Taxpayers who both timely pay tax by Electronic Funds Transfer and timely file returns and schedules electronically shall be entitled to a 1.75% discount as follows: - or $1250, whichever is less, per liability period.

i) For original returns due on or after January 1, 2003 through September 30, 2003, the discount shall be 1.75% or $1,250 per return, whichever is less;

ii) For original returns due on or after October 1, 2003 through September 30, 2004, the discount shall be 2% or $3,000 per return, whichever is less; and

iii) For original returns due on or after October 1, 2004, the discount shall be 2% or $2,000 per return, whichever is less.
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B) Mandatory Electronic Payment of Taxes. Effective January 1, 2003, taxpayers whose annual liability is $200,000 or more for the preceding calendar year are required to make payments of tax by Electronic Funds Transfer as provided in 86 Ill. Adm. Code 750.

2) After a first return has been filed by any manufacturer or importing distributor, a return form will be mailed by the Department on or about the first day of each succeeding month to such manufacturer or importing distributor. However, it is the duty of each manufacturer and importing distributor to obtain forms, and failure to receive forms from the Department will not be an excuse for failing to file returns when and as required by the Act.

3) Each manufacturer or importing distributor is required to file a return for each month that his license is in full force and effect, irrespective of the fact that he may not have any tax liability to pay for that month.

4) In any case where business is permanently discontinued, or where a stock of alcoholic liquors has been sold in bulk and the taxpayer has gone out of business, such taxpayer should immediately notify the Department of this fact, and upon a proper showing by such taxpayer that his license has been canceled by the Illinois Liquor Control Commission, he will be permitted to discontinue filing monthly returns.

5) In completing the Liquor Revenue Return form, the amount of liquor manufactured, rectified, blended or bottled during the month must be included on the return by manufacturers of alcohol and spirits and by first and second class wine-makers. In the case of manufacturers of alcohol and spirits, this item shall include bottled alcoholic liquor produced by such manufacturer in Illinois and bulk alcoholic liquor for which a deduction is being claimed on any schedule accompanying the return. In the case of first and second class wine-making, this item shall include all wine (whether immediately bottled or not) produced by the wine-maker in Illinois. Wineries which are licensed as manufacturers, but not as first or second class wine-makers, do not report anything as manufactured, rectified, blended or bottled.

b) Schedules Accompanying Return of Manufacturer or Importing Distributor of Alcoholic Liquor:
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1) As part of the monthly return of a manufacturer or importing distributor of alcoholic liquor, and to be completed and filed supplementary thereto in specified instances, the Department requires the completion and filing of the schedules described hereinbelow. The totals of the several columns on each of the schedules must be carried to the corresponding columns and entered on proper lines according to the schedule designation on the monthly tax return.

2) In every instance where a manufacturer or importing distributor is required, by any particular schedule, to make a report of alcoholic liquors manufactured, imported, stored on hand or held in warehouses, purchased or otherwise acquired, sold or otherwise transferred, used, bottled, blended, fortified or rectified by him, he shall, to comply with the provisions of the Act, also include in the appropriate schedule the alcoholic liquors manufactured, imported, stored on hand or held in warehouses, purchased or otherwise acquired, sold or otherwise transferred, used, bottled, blended, fortified or rectified by him as agent for others.

A) Schedule "A" – Alcoholic Liquor Transactions. This schedule must be completed and filed monthly by each importing distributor who imports alcoholic liquors into this State. This schedule consists of a detailed itemization of such importations, and the importing distributor must include in it all such importations of alcoholic liquors, regardless of whether the merchandise is imported in bond or out of bond. The mere fact that a warehouse acting as agent for the importing distributor receives the merchandise and issues a warehouse receipt therefor does not relieve the importing distributor from reporting the transaction. All alcoholic liquors imported and stored in public or bonded warehouses, for the account of an importing distributor, must be reported by said importing distributor in this schedule at the time the alcoholic liquors are imported and receipt of the alcoholic liquors for the account of the importing distributor is acknowledged by the warehouse. This information may not be withheld until withdrawals of the alcoholic liquors from the warehouse are made. Items of this nature should be reported as importations into Illinois.

B) Schedule "F" – Alcoholic Liquor Transactions. In this schedule,
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manufacturers of alcohol and spirits report only bottled alcoholic liquors purchased tax-free, including transfers in bond covered by the issuance, transfer or negotiation of warehouse receipts. All other manufacturers and importing distributors, however, must report tax-free purchases of both bottled and bulk alcoholic liquors in this schedule, including transfers in bond covered by the issuance, transfer or negotiation of warehouse receipts. Bottled alcoholic liquors purchased tax-free and stored in public or bonded warehouses for the account of a manufacturer of alcohol and spirits and all alcoholic liquors purchased tax-free and stored in public or bonded warehouses for the account of other manufacturers (such as wineries) and importing distributors, must be reported in this schedule at the time of purchase, and such report may not be withheld until such alcoholic liquors are withdrawn from the warehouse.

C) Schedule "G" – Tax-Paid Inventory. This schedule must be completed by manufacturers and importing distributors who purchase tax-paid alcoholic liquors.

D) Schedule "C" – Tax-Free Alcoholic Liquor Sales in Interstate Commerce and Foreign Trade. This schedule must be filed by manufacturers or importing distributors who claim deductions on the monthly return of gallonage of alcoholic liquors sold by them and shipped tax-free in interstate or foreign commerce, or delivered tax-free to ships for use outside the continental limits of the United States in foreign commerce as provided in Section 420.140. Manufacturers and importing distributors must include in the schedule bulk (as well as all other) alcoholic liquors shipped tax-free in interstate or foreign commerce, or delivered tax-free to ships for use outside the continental limits of the United States in foreign commerce as provided in Section 420.140.

i) Each manufacturer who includes tax exempt sales of bulk alcoholic liquor in this schedule must verify that the quantity so sold has been included in his Liquor Revenue Return inventory.

ii) A separate Schedule "C" – Tax-Free Alcoholic Liquor Sales in Interstate Commerce and Foreign Trade must be
E) Schedule "B" – Tax-Free Sales of Alcoholic Liquors to Other Illinois-Licensed Manufacturers and Importing Distributors. This schedule must be filed by manufacturers or importing distributors who sell alcoholic liquors tax-free to other licensed manufacturers or importing distributors in Illinois. Each manufacturer, who includes in this schedule tax-free sales of bulk alcoholic liquors, must verify that the quantity so sold has been included in his Liquor Revenue Return inventory. Manufacturers and importing distributors must include in this schedule tax-free sales and transfers of alcoholic liquors in bond, including alcoholic liquors covered by original, transferred or negotiated warehouse receipts.

F) Schedule "E" – Tax-Free Alcoholic Liquor Sales for Non-Beverage Purposes. This schedule must be filed by manufacturers and importing distributors who claim deductions on the monthly return for tax-free sales of alcoholic liquors made to holders of non-beverage user's licenses. Original permits or coupons permitting the tax-free purchase of alcoholic liquors for non-beverage purposes must accompany this schedule. This schedule must also be filed by manufacturers and importing distributors who claim deductions on the monthly return for tax-free sales of alcoholic liquors to the United States or to a foreign government, their departments, agencies or instrumentalities, for non-beverage purposes. Each manufacturer, who includes in this schedule sales of bulk alcoholic liquors, must verify that the quantity so sold has been included in his Liquor Revenue Return inventory. Sales of wine for sacramental purposes must be reported as sales for non-beverage purposes. The seller should keep in its books and records certifications covering each delivery, and statements signed by the minister, priest or rabbi, showing the quantity of wine in each delivery together with a statement that the wine will be used only for sacramental purposes (see Section 420.70 of this Part).

G) Schedule "J" – Report of Alcoholic Liquors Lost, Destroyed, or Damaged During Production and Bottling. Losses incurred during production and bottling alcoholic liquors carried in inventory on the Liquor Revenue Return at the time when such bottling loss occurs must be listed on this schedule. Bottling losses will not be
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allowed as tax exempt unless accurate records are maintained and the deduction on the return is supported by this schedule.

H) Schedule for "Other Illinois Liquor Tax Deductions". This schedule should be used when manufacturers or importing distributors claim deductions on the monthly return for a gallonage of alcoholic liquors that may not be properly addressed by any of the other schedules supplied by the Department. Deductions claimed should be explained in detail and filed with the monthly return. Claimed exemptions from the tax will not be allowed at the time of audit unless supported by competent documentary evidence. For example, if alcoholic liquors are dumped for the purpose of destroying the alcoholic liquors, claimed exemption from the tax will not be allowed unless supported by an affidavit of a Department representative who witnessed the destruction of the alcoholic liquors. The licensee should retain a copy of the affidavit. Each manufacturer, who includes in this schedule sales of bulk alcoholic liquors, must verify that the quantity so sold has been included in his Liquor Revenue Return inventory.

I) Schedule "D" – Tax-Free Bulk Purchases Used in Rectification, Bottling and Blending. This schedule must be filed by manufacturers of alcohol and spirits, and will consist of a detailed itemization of all purchases of alcoholic liquors in bulk only, to be used in rectification, bottling or blending, or for sale in original containers, with respect to which the Illinois Alcoholic Liquor Tax has not been paid. All such purchases of bulk alcoholic liquors must be included in this schedule irrespective of the fact that the alcoholic liquors are purchased in bond or imported in bond. The fact that a warehouse, acting as agent for such manufacturer, may receive the alcoholic liquors and issue a warehouse receipt therefor does not relieve the manufacturer from reporting the transaction. All bulk alcoholic liquors purchased tax-free in Illinois or imported into Illinois by a manufacturer of alcohol and spirits and stored in a public or bonded warehouse for his account must be reported in this schedule at the time such alcoholic liquors are purchased by such manufacturer and received by the warehouse, and this information may not be withheld until such alcoholic liquors are withdrawn from the warehouse. This is an information schedule only and is not to be entered on the monthly return.
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J) Returned Merchandise. Alcoholic liquors returned by Illinois licensees to vendors from whom such alcoholic liquors were purchased, and who are located outside of the State of Illinois, must be reported the same as a sale in interstate commerce on Schedule "C"– Tax-Free Sales in Interstate Commerce and Foreign Trade.

i) Alcoholic liquors returned to Illinois licensees by their customers located outside of the State of Illinois must be reported the same as an importation on Schedule "A" – Alcoholic Liquor Transactions.

ii) When untaxed alcoholic liquors are returned to a manufacturer or an importing distributor, both parties being Illinois licensees, the person returning such liquors will report the transaction on Schedule "B"– Tax-Free Alcoholic Liquor Sales to Licensed Manufacturers and Importing Distributors, and the one receiving the returned liquors will report on Schedule "F"– Alcoholic Liquor Transactions.

iii) Tax-paid alcoholic liquors returned to an Illinois manufacturer or importing distributor by someone in Illinois need not be scheduled by the person returning such liquors, but the person receiving the returned liquors must report the transaction on Schedule "G"– Tax-Paid Inventory, the same as a purchase of tax-paid alcoholic liquor.

c) Statement By Out-of-State Sellers Other Than Illinois Licensed Foreign Importers:
Out-of-State sellers, who are not licensed in Illinois as foreign importers, and who sell, to Illinois licensed importing distributors, beer, wine, or alcohol and spirits, which are located at some place in the United States outside Illinois, and which are shipped or otherwise delivered into Illinois, are required to file with the Department, within 15 days after the end of each month, on forms prescribed and furnished by the Department, a statement setting forth the names and addresses of the persons in Illinois to whom beer, wine or alcohol and spirits were so sold and shipped or otherwise delivered during the preceding month and the respective
quantities so sold and shipped or otherwise delivered.

d) Information Returns From Illinois Licensed Foreign Importers:

1) The Department has determined it to be necessary, for the proper performance of its functions and duties under the Act, to require licensed foreign importers who are not also licensed in Illinois as importing distributors of alcoholic liquor to file a monthly information return with the Department. Such return must be filed by the 15th day of the month following the month for which such return is filed. Such return shall contain such information as the Department may reasonably require.

2) It is not necessary for such special foreign importer information return to be filed by any foreign importer who is also licensed in Illinois as an importing distributor of alcoholic liquor.

(Source: Amended at 28 Ill. Reg. _______, effective _____________)

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1) **Heading of the Part:** TeleFile Program

2) **Code Citation:** 86 Ill. Adm. Code 770

3) **Section Numbers:**

<table>
<thead>
<tr>
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<tr>
<td>770.100</td>
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<td>770.105</td>
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<tr>
<td>770.130</td>
<td>Amendment</td>
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4) **Statutory Authority:** P.A. 93-0022

5) **A Complete Description of the Subjects and Issues Involved:** This emergency rulemaking implements the requirements of P.A. 93-0022 that require purchases of alcoholic liquor to be reported to the Department by liquor retailers and liquor wholesalers beginning on October 1, 2003. P.A. 93-0022 provides that the Department may adopt rules to require that such reporting be done in an electronic or telephonic format. New Section 130.552 of Part 130 requires that the statement of such liquor purchases be reported for each month on the retailer’s ST-1, Sales and Use Tax Return. This proposed rulemaking requires that liquor retailers file such returns using the Department’s TeleFile system.

6) **Will this proposed amendment replace an emergency amendment currently in effect?** Yes

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

8) **Does this proposed amendment contain incorporations by reference?** No

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

10) **Statement of Statewide Policy Objectives:** This rulemaking does not create a State mandate, nor does it modify any existing State mandates.

11) **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:

    Terry D. Charlton
DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENTS

Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794
Phone: (217) 782-2844

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Certain liquor stores, taverns, restaurants that sell liquor for on-premises consumption are required to report liquor purchases under the requirements of P.A. 93-0022.

B) Reporting, bookkeeping or other procedures required for compliance: Use of the telephone as part of the Department’s TeleFile program.

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 2003

The full text of the proposed amendments is identical to the text of the emergency amendments on page 18924 of this issue of the Illinois Register.
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of Part: Anhydrous Ammonia, Low Pressure Nitrogen Solutions, Equipment, Containers, and Storage Facilities

2) Code Citation: 8 Ill. Adm. Code 215

3) Section Numbers: Adopted Action:
   215.100 Repeal
   215.105 Repeal

4) Statutory Authority: Illinois Fertilizer Act of 1961, [505 ILCS 80]

5) Effective Date of Amendments: November 25, 2003

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

7) Does this amendment contain incorporations by reference? No

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

9) Notice of Proposal Published in Illinois Register: August 15, 2003; 27 Ill. Reg. 13669

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

11) Differences between proposal and final version: None

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

13) Will these amendments replace an emergency rule currently in effect? Yes

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

15) Summary and Purpose of Amendments: The Department did a previous rulemaking reorganizing and revamping the language to the entire Part 215, Subpart A. It was intended that Sections 215.100 and 215.105 be deleted as the provisions in those Sections were incorporated into other existing Sections. However, in that rulemaking, those Sections were not permanently deleted; therefore, the Department is conducting this emergency amendment to permanently remove these Sections from Part 215, Subpart A.
DEPARTMENT OF AGRICULTURE

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

Linda Rhodes
Illinois Department of Agriculture
P. O. Box 19281, State Fairgrounds
Springfield, Illinois 62794-9281
217/785-5713
Fax: 217/785-4505

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

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER e: FERTILIZERS

PART 215
ANHYDROUS AMMONIA, LOW PRESSURE NITROGEN SOLUTIONS, EQUIPMENT, CONTAINERS, AND STORAGE FACILITIES

SUBPART A: ANHYDROUS AMMONIA, EQUIPMENT, CONTAINERS, AND STORAGE FACILITIES

Section 215.10 Scope
215.15 Definitions
215.20 Safety
215.25 Basic Rules
215.30 Location of Storage Tanks
215.35 Markings of Non-Refrigerated Containers and Systems other than DOT Containers
215.40 Container Appurtenances
215.45 Piping, Tubing and Fittings
215.50 Hose Specifications
215.55 Safety Relief Devices
215.60 Filling Densities
215.65 Transfer of Liquids
215.70 Liquid Level Gauging Devices
215.75 Painting of Containers
215.80 Electrical Equipment and Wiring
215.85 Systems Utilizing Stationary, Pier-Mounted or Skid-Mounted Aboveground Non-Refrigerated Storage
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215.90 Refrigerated Storage
215.95 Tank Car Operations
215.100 Systems Utilizing Stationary, Pier-Mounted or Skid-Mounted Aboveground or Underground Non-Refrigerated Storage (Repealed)
215.105 Systems Mounted on Farm Wagons (Implements of Husbandry) for the Transportation of Anhydrous Ammonia (Repealed)
215.110 Systems Mounted on Farm Wagons (Nurse Tanks) for the Transportation of Anhydrous Ammonia
215.115 Systems Mounted on Equipment for the Application of Anhydrous Ammonia
215.120 Administrative Hearings

SUBPART B: NITROGEN FERTILIZER SOLUTIONS

Section
215.200 General
215.205 Definitions
215.210 Application of Rules
215.215 Requirement of Construction and Original Test of Containers
215.220 Capacity of Containers
215.225 Container Valves and Accessories
215.230 Piping, Tubing and Fittings
215.235 Hose Specifications
215.240 Safety Devices
215.245 Transfer of Liquids
215.250 Tank Car Loading and Unloading Points and Operations
215.255 Liquid Level Gauging Devices
215.260 Indicating Devices
215.265 Storage Installations for Nitrogen Fertilizer Solutions
215.270 Systems Mounted on Trucks, Semi-trailers and Trailers for Transportation of Nitrogen Fertilizer Solutions
215.275 Systems Mounted on Vehicles and Implements of Husbandry for the Transportation of Nitrogen Fertilizer Solutions
215.280 Systems Mounted on Vehicles and Implements of Husbandry for the Application of Nitrogen Fertilizer Solutions
215.285 Administrative Hearings

215.TABLE A Rate of Discharge
215.TABLE B Guide for Selection of Materials for Refrigerated Ammonia Storage Tanks
215.TABLE C Minimum Material Requirements for Shells and Bottoms of Refrigerated Storage Tanks for Various Temperatures and Thicknesses
215.TABLE D Repair Welding
AUTHORITY: Implementing and authorized by Section 14 of the Illinois Fertilizer Act of 1961 [505 ILCS 80/14].


SUBPART A: ANHYDROUS AMMONIA, EQUIPMENT, CONTAINERS, AND STORAGE FACILITIES

Section 215.100 Systems Utilizing Stationary, Pier-Mounted or Skid-Mounted Aboveground or Underground Non-Refrigerated Storage (Repealed)

a) Design, working pressure and classification of containers:
   1) Containers shall be constructed in accordance with 8 Ill. Adm. Code Section 215.25 with a minimum design pressure of 250 psig. Because of insulating effects of the earth, the average vapor pressure of products stored in underground containers will be materially lower than when stored aboveground. This reduction in actual operating pressure, therefore, provides a substantial corrosion allowance for these containers when installed underground.
   2) U-68 and U-69 ASME Code containers with a design pressure of 200 psig are acceptable if recertified to 250 psig and equipped with safety relief valves set at 250 psig as stated in 8 Ill. Adm. Code Section 215.55(b).

b) Installation of Storage Containers:
   1) Aboveground installation of anhydrous ammonia containers is recommended.
   2) Containers installed aboveground shall be installed on reinforced concrete footings or foundations or structural steel supports mounted on reinforced concrete foundations. The reinforced concrete foundations or footings must extend below the established frost line and shall be of sufficient width and thickness to support the total weight of the containers and contents adequately. The foundations shall maintain the lowest point of
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...the tank at not less than 24 inches above the ground. I beams shall support the weight of the tank and product. Skid-mounted units shall include all piping and pumps or compressors as one unit. If the design of such a unit precludes a minimum of 24 inches ground-to-tank clearance, bottom-side inlet, outlet valves and piping are prohibited. Skid mounted anhydrous ammonia storage tanks must be installed on permanent concrete footings or adequate floating reinforced concrete slabs.

3) Horizontal aboveground containers shall be mounted on foundations in such a manner as to permit expansion and contraction. Every container shall be supported so as to prevent the concentration of excessive loads on the supporting portion of the shell. Means of preventing corrosion shall be provided on that portion of the container in contact with the foundations or saddles.

4) Secure anchorage or adequate pier height shall be provided against container flotation wherever high flood water might occur.

5) Containers buried underground shall be placed so that the top of the container is at least one foot below the surface of the ground. Should ground conditions make compliance with this requirement impracticable, precautions, such as guard rails, shall be taken to prevent physical damage to the container. It will not be necessary to cover the portion of the container to which a manhole and other connections are affixed. When necessary to prevent flotation, containers shall be securely anchored or weighted.

6) Underground containers shall be set on firm foundations (firm earth may be used) and surrounded with soft earth or sand well tamped in place. As a further means of resisting corrosion, the container, prior to being placed underground, shall be given a protective coating equivalent to hot dip galvanizing or two preliminary coatings of red lead followed by a heavy coating of coal tar or asphalt. The coated container shall be lowered into place in such a manner as to prevent abrasion or other damage to the coating.

7) Distance between aboveground containers over 2000 gallons capacity shall be at least five feet.

c) Container valves and accessories:

1) All containers shall be equipped with a fixed liquid level gauge.

2) All containers shall be equipped with a vapor pressure indicating gauge having a dial graduated from 0-400 psig.

3) The filling connection shall be fitted with an approved combination back-pressure check valve, excess flow valve, or a positive shutoff valve in conjunction with either an internal back-pressure check valve or an internal excess flow valve.
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4) All containers shall be equipped with an approved vapor return valve.
5) All vapor and liquid connections, except safety relief valves and those specifically exempt in this section, shall be equipped with approved excess-flow valves or fitted with approved remote controlled quick-closing internal valves which shall remain closed, except during operating periods.

d) Safety devices: Every container shall be provided with one or more safety relief valves of the spring-loaded type and shall comply with the following:
1) The discharge from safety relief valves shall be directed upward, unobstructed into the open air, and away from the container. Vent pipes shall not be restricted nor smaller in size than the relief valve outlet connection. All relief valve discharges shall have raincaps that will allow the free discharge of the vapor and prevent the entrance of water. Provision shall be made for draining condensation which may accumulate.
2) Vent pipes from two or more safety relief devices located on the same unit or similar lines from two or more different units may be run into a common header, provided the cross-sectional area of the header is at least equal to the sum of the cross-sectional area of the individual vent pipes.

e) Underground containers:
1) Spring-loaded relief valves installed on underground containers may be reduced to a minimum of 30 percent of the rate of discharge specified in 8 Ill. Adm. Code Section 215.Table A. Containers so protected shall not be uncovered after installation until the liquid anhydrous ammonia has been removed. Containers which may contain liquid anhydrous ammonia before being installed underground and before completely covered with earth are to be considered aboveground containers when determining the rate of discharge requirement of the relief valves.
2) The discharge from vent pipes should be above the possible water level on underground installation where there is a probability that the manhole or housing may become flooded. All manholes or housings shall be provided with ventilated louvers or their equivalent. The area of such openings shall equal or exceed the combined discharge areas of safety relief valves and vent pipes that discharge their content into the manhole housing.

f) Marking containers: Each tank or group of tanks shall be marked on at least two approaching sides with the words "Caution-Ammonia" or "Caution-Anhydrous Ammonia" in sharply contrasting colors with letters not less than four inches high.

g) Capacity of containers: Individual storage container capacity shall be limited only by good engineering practice (according to The Code).

h) Protection of tank accessories and grounding:
1) Valves and other appurtenances shall be protected against tampering and physical damage. Such appurtenances shall also be protected during the
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transit of containers intended for installation underground.

2) All connections to underground containers shall be located within a metal dome, housing, or manhole fitted with a metal removable cover.

3) Storage tanks need not be grounded. Where an electrical system exists, such as for lights or pump motors, the electrical system shall be installed and grounded in a manner as required by the National Electrical Code or local ordinance.

4) All areas occupied by storage installations shall be kept free of dry grass and weeds. Manually controlled valves, which if open would allow anhydrous ammonia to discharge into the atmosphere, shall be kept secured when the installation is unattended.

5) The owner of an abandoned storage system shall be responsible for its maintenance, safe disposal of anhydrous ammonia, and shall keep the storage site free of dry grass and weeds.

i) Reinstallation of containers: Containers once installed underground shall not later be installed aboveground or underground, unless they successfully withstand hydrostatic pressure tests at the pressure specified for the original hydrostatic test as required by The Code under which the container was constructed and show no evidence of serious corrosion. Reinstalled containers must also comply with 8 Ill. Adm. Code Section 215.100(c).

(Source: Repealed at 27 Ill. Reg. 18536, effective November 25, 2003)

Section 215.105 Systems Mounted on Farm Wagons (Implements of Husbandry) for the Transportation of Anhydrous Ammonia (Repealed)

a) This section applies to containers of 2000 gallons capacity or less and pertinent equipment mounted on farm wagons (implements of husbandry) and used for the transportation of anhydrous ammonia. 8 Ill. Adm. Code Sections 215.25 throughs 215.95 apply to this section unless otherwise noted.

b) Design, working pressure and classification of containers:

1) Containers shall be constructed in accordance with Section 215.25 with a minimum design pressure of 250 psig.

2) The shell or head thickness of any container shall not be less than \( \frac{3}{16} \) of an inch.

3) All containers over 500 gallons capacity should be equipped with semi-rigid baffle plates.

c) Mounting containers:

1) Stop or stops shall be mounted on the truck, semi-trailer, or trailer or on the container in such a way that the container shall not be dislodged from its mounting due to the vehicle coming to a sudden stop. Back slippage
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shall also be prevented:

2) A hold-down device shall be provided which will anchor the container to the vehicle at one or more places on each side of the container.

3) When containers are mounted on four-wheel trailers, care shall be taken to insure that the weight is distributed evenly over both axles.

4) When the cradle and the tank are not welded together, material shall be used between the two to eliminate metal to metal friction.

d) Container valves and accessories:

1) All containers shall be equipped with a fixed liquid level gauge.

2) All containers with a capacity of 250 gallons or more shall be equipped with a pressure indication gauge having a dial graduated from 0-400 psig.

3) The filling connection shall be fitted with a positive shutoff valve in conjunction with either an internal back pressure check valve or an internal excess flow valve.

4) All containers with a capacity exceeding 250 gallons shall be equipped for spray loading or with a vapor return valve.

5) All vapor liquid connections, except safety relief valves and those specifically exempt in 8 Ill. Adm. Code Section 215.40 shall be equipped with excess flow valves or quick closing internal valves which shall remain closed except during operating periods.

6) Fittings shall be adequately protected from physical damage by:

A) A metal box or cylinder with an open top securely fastened to the container;

B) Rigid guards, well braced, welded to the container on both sides of the fittings; or

C) A metal dome. If a metal dome is used, the relief valve shall be properly vented through the dome.

7) If a liquid withdrawal line is installed in the bottom of the container, the connections thereto, including hose, shall not be lower than the lowest horizontal edge of the vehicle axle.

8) Both ends of the hose shall be made secure while in transit.

e) Marking:

1) Placard: Four (4) diamond type, non-flammable, Department of Transportation gas placards shall be displayed (one on each side and one on each end).

2) Marking: The words "Anhydrous Ammonia" shall appear on each side and each end in letters no less than two (2) inches high.

3) The words "Liquid" or "Vapor" shall be placed on or within 12 inches of the appropriate valve by means of stencil, tag, decal, or color coding with a legible legend ORANGE LIQUID and YELLOW VAPOR on the tank.

f) Farm wagons (implements of husbandry):
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1) Farm wagons (implements of husbandry) are as defined in the Illinois Motor Vehicle Code, Ill. Rev. Stat. 1979, Ch. 95½, paragraph 1-130).

2) All farm wagons shall be securely attached to the vehicle drawing them by means of drawbars supplemented by safety chains of sufficient size and strength to prevent the towed vehicle parting from the drawing vehicle in case of drawbar should break or become disengaged.

3) A farm wagon shall be constructed so that it will follow substantially in the path of the towing vehicle and will prevent the towed farm wagon from dangerously whipping or swerving from side to side.

4) All farm wagons shall have at least five (5) gallons of readily available clean water.

5) Storage of Containers: When a nurse tank containing 10% or more of anhydrous ammonia is at an unattended approved storage site, the manually controlled valves shall be secured against tampering or the nurse tank shall be stored inside a locked, fenced enclosure. Nurse tanks shall be stored no less than 50 feet from the edge of the adjacent road, 150 feet from place of private or public assembly, and 750 feet from place of institutional occupancy. All pressure and liquid level gauges must be in working order.

(Source: Repealed at 27 Ill. Reg. 18536, effective November 25, 2003)
DEPARTMENT OF AGRICULTURE

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1) **Heading of Part:** Weights and Measures Act

2) **Code Citation:** 8 Ill. Adm. Code 600

3) **Section Number:** 600.310  
   **Adopted Action:** Amend

4) **Statutory Authority:** Weights and Measures Act [225 ILCS 470]

5) **Effective Date of Amendments:** November 25, 2003

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

7) **Does this amendment contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 11, 2003; 27 Ill. Reg. 10138

10) **Has JCAR issued a Statement of Objection to this amendment?** No

11) **Differences between proposal and final version:** None

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

13) **Will this amendment replace an emergency amendment currently in effect?** Yes

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

15) **Summary and Purpose of Amendment:** The Bureau of Weights and Measures inspects all commercially-used weighing and measuring devices in the State of Illinois. The Bureau is mandated to inspect all known devices within a 12-month period, and device owners are charged a fee for the inspection. The FY04 budget is based upon fee increases proposed by the Governor’s Office of Management and Budget. The additional revenue will be used to support the Weights and Measures Program.

16) **Information and questions regarding this adopted amendment shall be directed to:** Linda Rhodes
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

Illinois Department of Agriculture
State Fairgrounds
Springfield, IL 62794-9281
217/785-5713
Fax: 217/785-4505

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

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER p: WEIGHTS AND MEASURES

PART 600
WEIGHTS AND MEASURES ACT

SUBPART A: PACKAGING AND LABELING

Section
600.1 National Institute of Standards and Technology Handbook 130
600.10 Definitions (Repealed)
600.20 Application (Repealed)
600.30 Identity (Repealed)
600.40 Declaration of Identity: Nonconsumer Package (Repealed)
600.50 Declaration of Responsibility: Consumer and Nonconsumer Packages (Repealed)
600.60 Declaration of Quantity: Consumer Packages (Repealed)
600.70 Declaration of Quantity: Nonconsumer Packages (Repealed)
600.80 Prominence and Placement: Consumer Packages (Repealed)
600.90 Prominence and Placement: Nonconsumer Package (Repealed)
600.100 Requirements: Specific Consumer Commodities, Packages, Containers (Repealed)
600.110 Exemptions (Repealed)
600.120 Variations to be Allowed (Repealed)
600.130 Standards of Fill (Repealed)
600.140 Wholesale and Retail Exemption
600.150 Revocation of Conflicting Regulations (Repealed)
600.160 Tables: Weights and Measures Standards for Illinois

SUBPART B: ROOFING AND ROOFING MATERIALS

Section
DEPARTMENT OF AGRICULTURE
NOTICE OF ADOPTED AMENDMENT

600.250 Roofing and Roofing Materials Shall Be Sold Either by the "Square" or by the "Square Yard." (Repealed)

SUBPART C: WEIGHING AND MEASURING DEVICES:
METERS – SCALES – FEES

Section
600.300 Vehicle Scales Regulation
600.310 Fees
600.320 Scales Used for the Enforcement of Highway Weight Laws
600.330 National Institute of Standards and Technology Handbook 44

SUBPART D: MOISTURE METER TESTING

Section
600.350 General (Repealed)
600.360 Testing and Inspection (Repealed)
600.370 Rejected Moisture Testing Devices (Repealed)
600.380 Use of Moisture Measuring Devices (Repealed)

SUBPART E: REGISTRATION OF SERVICE AGENCIES, SERVICEMEN,
AND SPECIAL SEALERS FOR COMMERCIAL
WEIGHING AND MEASURING DEVICES

Section
600.450 Policy (Repealed)
600.460 Definitions (Repealed)
600.470 Certificate of Registration (Repealed)
600.480 Types of Certificates (Repealed)
600.490 Examinations (Repealed)
600.500 Exemptions (Repealed)
600.510 Registration Fee (Repealed)
600.520 Reports (Repealed)
600.530 Bonds (Repealed)
600.540 Standards and Testing Equipment (Repealed)
600.550 Revocation of Certificate of Registration (Repealed)
600.560 Publication of Lists (Repealed)

SUBPART F: LIQUID PETROLEUM MEASURING DEVICES
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

Section
600.650 Use of Gasoline Pumps Which Are Not Capable of Computing the Prices Which Exceed 99.9¢ Per Gallon
600.660 Retail Liquid Petroleum Pumps Accurately Marked: Liters or Gallons
600.670 System Used to Sell Petroleum Product
600.680 Unit Price Per Gallon Displayed (Repealed)
600.690 Price of Gasoline
600.700 Unit Price Indicator: Set at One-Half Total Selling Price
600.710 Decals or Stickers Affixed to the Pump Face
600.720 Information Sign Indicating Half Gallon Pricing of Gasoline
600.730 Conversion Kits or Replacement Pumps: Deadline (Repealed)
600.740 Three-Wheel Computers Prohibited
600.750 One-Half Gallon Pricing Applicable to All Metering Pumps at Facility
600.760 Stop Use Order; Hearing

SUBPART G: ADVERTISEMENT OF THE PRICE OF LIQUID PETROLEUM PRODUCTS

Section
600.800 Price Per Gallon or Liter in Advertisement
600.810 Height and Width of Numbers
600.820 Advertised Price Complete
600.830 Advertising Other Commodities; Misleading Advertising Prohibited
600.840 Product Identity and Type of Service
600.850 Advertisement of Price Not Required Except on Pump
600.860 Stop Use Order; Hearing

TABLE A Minimum Height of Numbers and Letters (Repealed)
TABLE B Standard Weight Per Bushel for Agricultural Commodities
TABLE C Illinois Standard Weights and Measures
TABLE D Equivalents: Cubic Inches in U.S. Standard Capacity Measures
TABLE E Weights of Coal Per Cubic Foot
TABLE F Equivalents to be used by Seller in Transposing Weights
TABLE G Measurement of Surfaces and Volumes

AUTHORITY: Implementing and authorized by Section 8 of the Weights and Measures Act [225 ILCS 470/8].


SUBPART C: WEIGHING AND MEASURING DEVICES:
METERS – SCALES – FEES

Section 600.310 Fees

The Director of Agriculture and each city sealer of weights and measures shall collect and receive fees for the use of the State or city as the case may be at the following rates, which shall be due and payable at the time of such inspection. Per hour fee is charged for each hour or portion thereof.

<table>
<thead>
<tr>
<th>DEVICE</th>
<th>CURRENT FEE</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scales by capacity 0-50 pounds</td>
<td>10</td>
<td>14</td>
<td>1842</td>
<td>13</td>
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<tr>
<td>Scales by capacity 51-2000 pounds</td>
<td>25</td>
<td>25</td>
<td>3925</td>
<td>25</td>
</tr>
<tr>
<td>Scales by capacity 2001 + pounds</td>
<td>100</td>
<td>110</td>
<td>186124</td>
<td>133</td>
</tr>
<tr>
<td>Additional readouts</td>
<td>0</td>
<td>25</td>
<td>3925</td>
<td>25</td>
</tr>
<tr>
<td>Railroad track</td>
<td>50</td>
<td>55</td>
<td>9461</td>
<td>67</td>
</tr>
</tbody>
</table>
## NOTICE OF ADOPTED AMENDMENT

### scales per hour

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate 1</th>
<th>Rate 2</th>
<th>Rate 3</th>
<th>Rate 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of scale truck per hour</td>
<td>100</td>
<td>110</td>
<td>186424</td>
<td>133</td>
</tr>
<tr>
<td>Belt conveyor scales per hour</td>
<td>100</td>
<td>110</td>
<td>186424</td>
<td>133</td>
</tr>
<tr>
<td>Livestock scales</td>
<td>100</td>
<td>110</td>
<td>186424</td>
<td>133</td>
</tr>
<tr>
<td>Motor fuel dispensers</td>
<td>10</td>
<td>11</td>
<td>1812</td>
<td>13</td>
</tr>
<tr>
<td>Motor fuel meters up to 2(\frac{3}{4})&quot;</td>
<td>50</td>
<td>55</td>
<td>9464</td>
<td>67</td>
</tr>
<tr>
<td>Motor fuel meters over 2(\frac{3}{4})&quot;</td>
<td>100</td>
<td>110</td>
<td>186424</td>
<td>133</td>
</tr>
<tr>
<td>LPG meters</td>
<td>75</td>
<td>83</td>
<td>14094</td>
<td>100</td>
</tr>
<tr>
<td>Mass flow meters per hour</td>
<td>0</td>
<td>55</td>
<td>9464</td>
<td>67</td>
</tr>
<tr>
<td>Grain moisture meters</td>
<td>50</td>
<td>55</td>
<td>9464</td>
<td>67</td>
</tr>
<tr>
<td>Metrology lab fee per hour plus shipping</td>
<td>75</td>
<td>83</td>
<td>14094</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source: Amended at 27 Ill. Reg. 18546, effective November 25, 2003)
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

1) **Heading of Part:** Livestock Management Facility Regulations

2) **Code Citation:** 8 Ill. Adm. Code 900

3) **Section Number:** 900.407  
   **Adopted Action:** Amend

4) **Statutory Authority:** Authorized by Section 55 of the Livestock Management Facilities Act and implementing the Livestock Management Facilities Act [510 ILCS 77]

5) **Effective Date of Amendment:** November 25, 2003

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

7) **Does this amendment contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 25, 2003; 27 Ill. Reg. 11326

10) **Has JCAR issued a Statement of Objection to this amendment?** No

11) **Differences between proposal and final version:** None

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

13) **Will this amendment replace any emergency amendment currently in effect?** Yes

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

15) **Summary and Purpose of Amendment:** A review of Department decisions pursuant to the Administrative Review Law has been found to be improper by circuit courts. This amendment therefore deletes reference to Administrative Review Law.

16) **Information and questions regarding this adopted amendment shall be directed to:**

   Linda Rhodes  
   Illinois Department of Agriculture  
   State Fairgrounds
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

Springfield, IL 62794-9281
217/785-5713
Fax: 217/785-4505

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

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER t: WASTE MANAGEMENT

PART 900
LIVESTOCK MANAGEMENT FACILITY REGULATIONS

SUBPART A: GENERAL PROVISIONS

Section 900.101 Applicability
900.102 Severability
900.103 Definitions
900.104 Incorporations by Reference
900.105 Recordkeeping

SUBPART B: SETBACKS

Section 900.201 Applicability
900.202 Procedures
900.203 Penalties

SUBPART C: NOTICE OF INTENT TO CONSTRUCT

Section 900.301 Applicability
900.302 Filing
900.303 Procedures
900.304 Establishment of Base Date and Setback Period
900.305 Penalties

SUBPART D: PUBLIC INFORMATIONAL MEETING

Section 900.401 Applicability
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

900.402 Notice
900.403 Request for Informational Meeting
900.404 Notice of Informational Meeting
900.405 Conduct of Informational Meeting
900.406 County Board Recommendation
900.407 Final Determination
900.408 Amendment to Plans
900.409 Construction

SUBPART E: LIVESTOCK WASTE HANDLING FACILITIES OTHER THAN LAGOONS

Section
900.501 Applicability
900.502 Siting Restrictions and Additional Construction Requirements
900.503 Livestock Waste Handling Facilities Not Subject to the Public Informational Meeting Process
900.504 Livestock Waste Handling Facilities Subject to the Public Informational Meeting Process
900.505 Inspections
900.506 Certification of Compliance
900.507 Failure to Register or File Construction Plans
900.508 Removal from Service
900.509 Return to Service
900.510 Odor Control
900.511 Perimeter Drainage Tubing Sampling, Analysis and Reporting Procedures

SUBPART F: LAGOON LIVESTOCK WASTE HANDLING FACILITIES

Section
900.601 Applicability
900.602 Lagoon Siting Restrictions and Additional Construction Requirements
900.603 Registration
900.604 Lagoon Construction, Registration, and Certification Inspections
900.605 Certification of Construction
900.606 Failure to Register or Construct in Accordance with Standards
900.607 Lagoon Operational Inspections
900.608 Lagoon Closure
900.609 Odor Control
900.610 Ownership Transfer
900.611 Perimeter Drainage Tubing Sampling, Analysis and Reporting Procedures
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

SUBPART G: LAGOON FINANCIAL RESPONSIBILITY

Section
900.701 Scope, Applicability, and Definitions
900.702 Mechanisms for Providing Evidence of Financial Responsibility
900.703 Level of Surety
900.704 Upgrading Surety Instrument
900.705 Release of Lagoon Owner and Financial Institution
900.706 Financial Responsibility Proceeds
900.707 Use of Multiple Surety Instruments
900.708 Use of a Single Surety Instrument for Multiple Lagoons
900.709 Commercial or Private Insurance
900.710 Guarantee
900.711 Surety Bond
900.712 Letter of Credit
900.713 Certificate of Deposit or Designated Savings Account
900.714 Participation in a Livestock Waste Lagoon Closure Fund
900.720 Penalties

SUBPART H: WASTE MANAGEMENT PLAN

Section
900.801 Purpose
900.802 Scope and Applicability
900.803 Waste Management Plan Contents
900.804 Livestock Waste Volumes
900.805 Nutrient Value of Livestock Waste
900.806 Adjustments to Nitrogen Availability
900.807 Targeted Crop Yield Goal
900.808 Nitrogen Credits
900.809 Records of Waste Disposal
900.810 Approval of Waste Management Plans
900.811 Sludge Removal
900.812 Soil Phosphorus Testing
900.813 Phosphorus Based Application
900.814 Plan Updates
900.815 Penalties
900.816 Odor Control

SUBPART I: CERTIFIED LIVESTOCK MANAGER
NOTICE OF ADOPTED AMENDMENT

Section 900.901 Applicability

900.APPENDIX A Surety Instruments
   ILLUSTRATION A Surety Bond
   ILLUSTRATION B Irrevocable Standby Letter of Credit

AUTHORITY: Authorized by Section 55 of the Livestock Management Facilities Act and implementing the Livestock Management Facilities Act [510 ILCS 77] (see P.A. 91-0110, effective July 13, 1999).


SUBPART D: PUBLIC INFORMATIONAL MEETING

Section 900.407 Final Determination

a) Within 15 calendar days after the close of the comment period under Section 900.406 of this Subpart, the Department shall determine:

1) That, more likely than not, the provisions of the Livestock Management Facilities Act [510 ILCS 77] have been met [510 ILCS 77/12.1(a)];

2) That, more than likely than not, the provisions of the Livestock Management Facilities Act [510 ILCS 77] have not been met; or

3) That additional information or specific changes are needed in order to assist the Department in making the determination.

b) If the Department determines after an informational meeting that, more likely than not, the provisions of the Livestock Management Facilities Act have been met, the Department shall send written notice by certified mail, return receipt requested, to the applicant and the county board indicating that construction may proceed provided the other applicable provisions of the Livestock Management Facilities Act have been met. [510 ILCS 77/12.1(a)]

c) If the Department determines after an informational meeting that, more likely than not, the provisions of the Livestock Management Facilities Act have not been met, the Department shall send written notice by certified mail, return receipt
DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENT

requested, to the applicant and the county board that construction is prohibited. [510 ILCS 77/12.1(a)] The notice shall also indicate include the reasons for the construction prohibition.

d) If the Department finds, after an informational meeting, that additional information or that specific changes are needed in order to assist the Department in making the determination, the Department may request such information or changes from the owner or operator of the new livestock waste handling facility or livestock management facility. [510 ILCS 77/12.1(a-5)] No later than 10 working days after the receipt of the clarification information, the Department shall notify the applicant and the county board in writing by certified mail, return receipt requested, whether, more likely than not, the provisions of the Livestock Management Facilities Act have been met and construction may proceed, whether additional information is required, or whether construction is prohibited.

e) If no informational meeting is held, the Department shall, within 15 calendar days following the end of the period for the county board to request an informational meeting, notify in writing by certified mail, return receipt requested, the owner or operator that construction may begin provided the other applicable provisions of the Livestock Management Facilities Act have been met, is prohibited or that clarification is needed. [510 ILCS 77/12.1(b)] No later than 10 working days after the receipt of the clarification information, the Department shall notify the applicant and the county board in writing by certified mail whether the provisions of the Livestock Management Facilities Act have been met and whether construction may proceed or is prohibited.

f) Final decisions of the Department are subject to judicial review pursuant to the Administrative Review Law [735 ILCS 5/Art. III]. For purposes of judicial review, the Department's decision becomes final as of the date of the decision. The procedure for stay or reconsideration of any final Department decision by the Department shall be as provided for in the Department's administrative rules at 8 Ill. Adm. Code 1.

(Source: Amended at 27 Ill. Reg. 18553, effective November 25, 2003 )
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:**
   - 310.280 Amended
   - 310.Appendix A, Table L Amended
   - 310.Appendix A Table W Amended

4) **Statutory Authority:** Authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a].

5) **Effective Date of Amendments:** December 1, 2003

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

7) **Do these amendments contain incorporations by reference?** No

8) A copy of the adopted amendments, including any material incorporated, 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.

9) **Notice of proposed amendments published in the Illinois Register:** May 30, 2003, Issue #22, 27 Ill. Reg. 8570

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

11) **Differences between proposal and final version:**
    - In line 105, strike "administrative" and add "Administrator".
    - In line 241, after "peremptory" add "amendment".
    - In line 261, change the comma to a semicolon.
    - In line 268, after semicolon add "emergency expired November 27, 2000;".
    - In line 291, after the semicolon add "emergency expired March 22, 2003;".
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

In line 295, after the semicolon add "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;".

In line 296, add "SUBPART B: SCHEDULE OF RATES".

In the Table after line 301, remove the gridlines from the table.

In the Table, strike "Department of Central Management Services".

In the Table, strike "Department of Commerce & Community Affairs" and add "Department of Commerce & Economic Opportunity".

In the Table, in the first item under "Department of Commerce & Economic Opportunity", change the salary from "59,376" to "63,840".

In the Table, in the two items under the "Department of State Police", change the salary from "$113,580" to "$117,828".

In 310.Appendix A, Table L, after line 307, change "4,524.00" to "4524.00" and "5,976.90" to "5976.90".

In 310.Appendix A, Table W, add "Labor Conciliator", "RC-062-20", and "22750" and remove obsolete dated tables per peremptory amendment at 27 Ill. Reg. 17433, effective 11/7/03.

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 these amendments replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? Yes

<table>
<thead>
<tr>
<th>Section Numbers</th>
<th>Proposed Action</th>
<th>Ill. Reg. Citation</th>
</tr>
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<tbody>
<tr>
<td>310.280</td>
<td>Amend</td>
<td>27 Ill. Reg. 9656, 7/7/03</td>
</tr>
<tr>
<td>310.Appendix A, Table W</td>
<td>Amend</td>
<td>27 Ill. Reg. 9656, 7/7/03</td>
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<tr>
<td>310.80</td>
<td>Amend</td>
<td>27 Ill. Reg. 10442, 7/11/03</td>
</tr>
<tr>
<td>310.100</td>
<td>Amend</td>
<td>27 Ill. Reg. 10442, 7/11/03</td>
</tr>
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<td>310.130</td>
<td>Amend</td>
<td>27 Ill. Reg. 10442, 7/11/03</td>
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<tr>
<td>310.220</td>
<td>Amend</td>
<td>27 Ill. Reg. 10442, 7/11/03</td>
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</table>
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

310.230  Amend  27 Ill. Reg. 10442, 7/11/03
310.290  Amend  27 Ill. Reg. 10442, 7/11/03
310.450  Amend  27 Ill. Reg. 10442, 7/11/03
310.530  Amend  27 Ill. Reg. 10442, 7/11/03
310.540  Amend  27 Ill. Reg. 10442, 7/11/03
310.Appendix B  Amend  27 Ill. Reg. 10442, 7/11/03
310.Appendix C  Amend  27 Ill. Reg. 10442, 7/11/03
310.Appendix D  Amend  27 Ill. Reg. 10442, 7/11/03
310.Appendix G  Amend  27 Ill. Reg. 10442, 7/11/03
310.230  Amend  27 Ill. Reg. 17304, 11/21/03
310.280  Amend  27 Ill. Reg. 17304, 11/21/03
310.Appendix A, Table AB  Amend  27 Ill. Reg. 17304, 11/21/03

15) Summary and Purpose of Amendments: Section 310.280, Designated Rate, the Senior Public Service Administrator position (400070-37-00-000-05-01) in the Department of Central Management Services is a designated rate no longer required.

Section 310.Appendix A, Table L, RC-008 (Boilermakers), the salary range for the Boiler Safety Specialist is changed to $4,524.00-$5,976.90 to conform with rates as negotiated in a Memorandum of Agreement.

Section 310.Appendix A, Table W, RC-062 (Technical Employees, AFSCME), the abolished titles of Computer Information Consultant Trainee and Computer Systems Software Specialist Trainee are deleted by action of the Civil Services Commission and per a July 2000 Memorandum of Understanding with AFSCME.

The Liquor Control Special Agent II title is no included in the RC-062 Collective Bargaining Unit.

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

Ms. Marianne Armento
Department of Central Management Services
Division of Technical Services
504 William G. Stratton Building
Springfield IL  62706
217/782-5601
Fax:  217/524-4570
Department of Central Management Services

Notice of Adopted Amendments

17) Do these amendments require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 50/5-25]? No

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

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
310.50 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 for Fiscal Year 2003
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
310.240 Hourly Rate
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

310.250 Member, Patient and Inmate Rate
310.260 Trainee Rate
310.270 Legislated and Contracted Rate
310.280 Designated Rate
310.290 Out-of-State or Foreign Service Rate
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
310.330 Excluded Classes Rate (Repealed)

SUBPART C: MERIT COMPENSATION SYSTEM

Section
310.410 Jurisdiction
310.420 Objectives
310.430 Responsibilities
310.440 Merit Compensation Salary Schedule
310.450 Procedures for Determining Annual Merit Increases
310.455 Intermittent Merit Increase
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 Guidechart for Fiscal Year 2003
310.550 Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

310.APPENDIX A Negotiated Rates of Pay
    310.TABLE A HR-190 (Department of Central Management Services – State of Illinois Building – SEIU)
    310.TABLE AA NR-916 (Department of Natural Resources, Teamsters)
    310.TABLE AB VR-007 (Plant Maintenance Engineers, Operating Engineers)
    310.TABLE B HR-200 (Department of Labor - Chicago, Illinois – SEIU)
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Repealed)

310.TABLE C  RC-069 (Firefighters, AFSCME) (Repealed)
310.TABLE D  HR-001 (Teamsters Local #726)
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  HR-012 (Fair Employment Practices Employees, SEIU)

(Repealed)
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, AFSCME)
310.TABLE Z  RC-063 (Physicians, AFSCME)

310.APPENDIX B  Schedule of Salary Grades – Monthly Rates of Pay for Fiscal Year 2003
310.APPENDIX C  Medical Administrator Administrative Rates for Fiscal Year 2003
310.APPENDIX D  Merit Compensation System Salary Schedule for Fiscal Year 2003
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 for Fiscal Year 2003

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a.]

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

peremptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; emergency amendment at
1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440,
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; peremptory amendment at 10 Ill. Reg. 3325,
effective January 22, 1986; amended at 10 Ill. Reg. 3230, effective January 24, 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
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS


SUBPART B: SCHEDULE OF RATES

Section 310.280 Designated Rate

The rate of pay for a specific position or class of positions where it is deemed desirable to exclude such from the other requirements of this Pay Plan shall be only as designated by the Governor.

Department of Central Management Services

<table>
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<tr>
<th>Senior Public Service Administrator</th>
<th>Annual Salary</th>
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<tbody>
<tr>
<td>(Pos. No. 40070-37-00-000-05-01)</td>
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Department of Children & Family Services

Public Service Administrator  Annual Salary
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Pos. No. 37015-16-23-120-00-01) 85,104

Department of Commerce & Economic Opportunity
Community Affairs

Administrative Assistant II
(Pos. No. 00502-42-00-040-11-01) Annual Salary 63,840

Public Information Officer IV
(Pos. No. 37004-42-00-005-10-01) Annual Salary 69,792

Public Service Administrator
(Pos. No. 37015-42-35-110-10-03) Annual Salary 78,612

Public Service Administrator
(Pos. No. 37015-42-35-140-20-01) Annual Salary 96,360

Department of Human Services

Administrative Assistant I
(Pos. No. 00501-10-68-010-80-21) Annual Salary 55,200

Medical Administrator I, Option D
(Pos. No. 26401-10-79-006-00-21) Annual Salary 142,368

Public Service Administrator
(Pos. No. 37015-10-23-100-30-01) Annual Salary 76,572

Senior Public Service Administrator
(Pos. No. 40070-10-65-000-00-01) Annual Salary 105,475

Senior Public Service Administrator
(Pos. No. 40070-10-81-920-00-21) Annual Salary 105,480

Illinois Labor Relations Board

Private Secretary II
(Pos. No. 34202-50-19-000-00-01) Annual Salary 51,900

Department of Natural Resources
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Administrative Assistant II
(Pos. No. 00502-12-30-000-20-01)  Annual Salary  50,520

Public Service Administrator
(Pos. No. 37015-25-61-140-80-01)  Annual Salary  76,668
Public Service Administrator
(Pos. No. 37015-25-61-140-90-01)  Annual Salary  74,904

Department of State Police
Senior Public Service Administrator
(Pos. No. 40070-21-10-000-00-01)  Annual Salary  117,828
Senior Public Service Administrator
(Pos. No. 40070-21-40-000-00-01)  Annual Salary  117,828

(Source: Amended at 27 Ill. Reg. 18560, effective December 1, 2003)

Section 310.APPENDIX A  Negotiated Rates of Pay

Section 310.TABLE L  RC-008 (Boilermakers)

Effective: September 1, 2002

<table>
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<tr>
<th>Title</th>
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(Source: Amended at 27 Ill. Reg. 18560, effective December 1, 2003)

Section 310.APPENDIX A  Negotiated Rates of Pay

Section 310.TABLE W  RC-062 (Technical Employees, AFSCME)

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<td>Activity Therapist</td>
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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Activity Therapist Coordinator RC-062-17 00160
Actuarial Assistant RC-062-16 00187
Actuarial Examiner RC-062-16 00195
Actuarial Examiner Trainee RC-062-13 00196
Actuarial Senior Examiner RC-062-19 00197
Actuary I RC-062-20 00201
Actuary II RC-062-24 00202
Agricultural Market News Assistant RC-062-12 00804
Agricultural Marketing Generalist RC-062-14 00805
Agricultural Marketing Reporter RC-062-18 00807
Agricultural Marketing Representative RC-062-18 00810
Agriculture Land and Water Resource Specialist I RC-062-14 00831
Agriculture Land and Water Resource Specialist II RC-062-17 00832
Agriculture Land and Water Resource Specialist III RC-062-20 00833
Aircraft Pilot I RC-062-18 00955
Aircraft Pilot I (Eff. 07-01-01) RC-062-19 00955
Aircraft Pilot II RC-062-21 00956
Aircraft Pilot II (Eff. 07-01-01) RC-062-22 00956
Appraisal Specialist I RC-062-14 01251
Appraisal Specialist II RC-062-16 01252
Appraisal Specialist III RC-062-18 01253
Arts Council Associate RC-062-12 01523
Arts Council Program Coordinator RC-062-18 01526
Arts Council Program Representative RC-062-15 01527
Bank Examiner I RC-062-16 04131
Bank Examiner II RC-062-19 04132
Bank Examiner III RC-062-22 04133
Behavioral Analyst I RC-062-17 04351
Behavioral Analyst II RC-062-19 04352
Behavioral Analyst Associate RC-062-15 04355
Business Administrative Specialist RC-062-16 05810
Buyer RC-062-18 05900
Carnival and Amusement Safety Inspector RC-062-16 06550
Carnival and Amusement Safety Inspector Trainee RC-062-10 06555
Chemist I RC-062-16 06941
Chemist II RC-062-19 06942
Chemist III RC-062-21 06943
Child Protective Associate Investigator RC-062-15 07187
Child Protective Investigator RC-062-17 07188
Child Protective Lead Investigator RC-062-18 07189
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Child Welfare Staff Development Coordinator I RC-062-17 07201
Child Welfare Staff Development Coordinator II RC-062-19 07202
Child Welfare Staff Development Coordinator III RC-062-20 07203
Child Welfare Staff Development Coordinator IV RC-062-22 07204
Child Welfare Specialist RC-062-15 07211
Children and Family Service Intern – Option 1 RC-062-12 07241
Children and Family Service Intern – Option 2 RC-062-15 07242
Clinical Laboratory Technologist I RC-062-18 08220
Clinical Laboratory Technologist II RC-062-19 08221
Clinical Laboratory Technologist Trainee RC-062-14 08229
Communications Systems Specialist RC-062-23 08860
Community Management Specialist I RC-062-15 08891
Community Management Specialist II RC-062-17 08892
Community Management Specialist III RC-062-19 08893
Community Planner I RC-062-15 08901
Community Planner II RC-062-17 08902
Community Planner III RC-062-19 08903
Computer Information Consultant Trainee RC-062-14 08945
Computer Systems Software Specialist Trainee RC-062-14 09005
Conservation Education Representative RC-062-12 09300
Conservation Grant Administrator I RC-062-18 09311
Conservation Grant Administrator II RC-062-20 09312
Conservation Grant Administrator III RC-062-22 09313
Construction Program Assistant RC-062-12 09525
Correctional Counselor I RC-062-15 09661
Correctional Counselor II RC-062-17 09662
Correctional Counselor III RC-062-19 09663
Corrections Academy Trainer RC-062-17 09732
Corrections Apprehension Specialist RC-062-19 09750
Corrections Industries Marketing Representative RC-062-17 09803
Corrections Leisure Activities Specialist I RC-062-14 09811
Corrections Leisure Activities Specialist I (Eff. 07-01-01) RC-062-15 09811
Corrections Leisure Activities Specialist II RC-062-16 09812
Corrections Leisure Activities Specialist II (Eff. 07-01-01) RC-062-17 09812
Corrections Leisure Activities Specialist III RC-062-19 09813
Corrections Parole Agent RC-062-17 09842
Corrections Senior Parole Agent RC-062-19 09844
Criminal Intelligence Analyst I RC-062-18 10161
Criminal Intelligence Analyst II RC-062-20 10162
Criminal Intelligence Analyst Specialist RC-062-22 10165
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Criminal Justice Specialist I                      RC-062-16  10231
Criminal Justice Specialist II                    RC-062-20  10232
Curator of the Lincoln Collection                 RC-062-16  10750
Day Care Licensing Representative I               RC-062-15  11471
Developmental Disabilities Council Program Planner I  RC-062-12  12361
Developmental Disabilities Council Program Planner II RC-062-16  12362
Developmental Disabilities Council Program Planner III RC-062-18  12363
Dietitian                                         RC-062-14  12510
Dietitian (Eff. 07-01-01)                         RC-062-15  12510
Disability Claims Adjudicator I                   RC-062-15  12537
Disability Claims Adjudicator II                  RC-062-17  12538
Disability Claims Analyst                         RC-062-20  12540
Disability Claims Specialist                      RC-062-18  12558
Disaster Services Planner                         RC-062-19  12585
Document Examiner                                 RC-062-22  12640
Educator – Provisional                            RC-062-12  13105
Employment Security Manpower Representative I    RC-062-12  13621
Employment Security Manpower Representative II   RC-062-14  13622
Employment Security Program Representative        RC-062-14  13650
Employment Security Program Representative –     RC-062-14H 13651
Intermittent                                      
Employment Security Service Representative       RC-062-16  13667
Employment Security Specialist I                  RC-062-14  13671
Employment Security Specialist II                 RC-062-16  13672
Employment Security Specialist III                RC-062-19  13673
Employment Security Tax Auditor I                 RC-062-17  13681
Employment Security Tax Auditor II                RC-062-19  13682
Energy and Natural Resources Specialist I         RC-062-15  13711
Energy and Natural Resources Specialist II        RC-062-17  13712
Energy and Natural Resources Specialist III       RC-062-19  13713
Energy and Natural Resources Specialist Trainee   RC-062-12  13715
Environmental Health Specialist I                 RC-062-14  13768
Environmental Health Specialist II                RC-062-16  13769
Environmental Health Specialist III               RC-062-18  13770
Environmental Protection Associate                RC-062-12  13785
Environmental Protection Specialist I             RC-062-14  13821
Environmental Protection Specialist II            RC-062-16  13822
Environmental Protection Specialist III           RC-062-18  13823
Environmental Protection Specialist IV            RC-062-22  13824
Financial Institution Examiner I                  RC-062-16  14971
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Industrial Services Hygienist Trainee RC-062-12 21133
Instrument Designer RC-062-18 21500
Insurance Analyst III RC-062-14 21563
Insurance Analyst IV RC-062-16 21564
Insurance Company Field Staff Examiner RC-062-16 21608
Insurance Company Financial Examiner Trainee RC-062-13 21610
Insurance Performance Examiner RC-062-14 21671
Intermittent Unemployment Insurance Representative RC-062-12H 21689
Labor Conciliator RC-062-20 22750
Laboratory Equipment Specialist RC-062-18 22990
Laboratory Quality Specialist I RC-062-19 23021
Laboratory Quality Specialist II RC-062-21 23022
Laboratory Research Specialist I RC-062-19 23027
Laboratory Research Specialist II RC-062-21 23028
Land Acquisition Agent I RC-062-15 23091
Land Acquisition Agent II RC-062-18 23092
Land Acquisition Agent III RC-062-21 23093
Land Reclamation Specialist I RC-062-14 23131
Land Reclamation Specialist II RC-062-17 23132
Liability Claims Adjuster I RC-062-14 23371
Library Associate RC-062-12 23430
Life Sciences Career Trainee RC-062-12 23600
Liquor Control Special Agent II RC-062-15 23752
Local Housing Advisor I RC-062-14 24031
Local Housing Advisor II RC-062-16 24032
Local Housing Advisor III RC-062-18 24033
Local Revenue and Fiscal Advisor I RC-062-15 24101
Local Revenue and Fiscal Advisor II RC-062-17 24102
Local Revenue and Fiscal Advisor III RC-062-19 24103
Lottery Sales Representative RC-062-16 24515
Management Operations Analyst I RC-062-18 25541
Management Operations Analyst II RC-062-20 25542
Manpower Planner I RC-062-14 25591
Manpower Planner II RC-062-17 25592
Manpower Planner III RC-062-20 25593
Manpower Planner Trainee RC-062-12 25593
Medical Assistance Consultant I RC-062-13 26501
Medical Assistance Consultant II RC-062-16 26502
Medical Assistance Consultant III RC-062-19 26503
Mental Health Specialist I RC-062-12 26924
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Mental Health Specialist II  RC-062-14  26925
Mental Health Specialist III  RC-062-16  26926
Mental Health Specialist Trainee  RC-062-11  26928
Meteorologist  RC-062-18  27120
Methods and Procedures Advisor I  RC-062-14  27131
Methods and Procedures Advisor II  RC-062-16  27132
Methods and Procedures Career Associate I  RC-062-11  27135
Methods and Procedures Career Associate II  RC-062-12  27136
Methods and Procedures Career Associate Trainee  RC-062-09  27137
Metrologist Associate  RC-062-14  27146
Microbiologist I  RC-062-16  27151
Microbiologist II  RC-062-19  27152
Natural Resources Coordinator  RC-062-15  28831
Natural Resources Specialist  RC-062-18  28832
Natural Resources Advanced Specialist  RC-062-20  28833
Network Control Center Specialist  RC-062-21  28873
Network Control Center Technician I  RC-062-13  28875
Network Control Center Technician II  RC-062-16  28876
Network Control Center Technician Trainee  RC-062-10  28879
Paralegal Assistant  RC-062-14  30860
Police Training Specialist  RC-062-17  32990
Property Consultant  RC-062-15  34900
Property Tax Analyst I  RC-062-12  34921
Property Tax Analyst II  RC-062-14  34922
Public Aid Appeals Advisor  RC-062-18  35750
Public Aid Family Support Specialist I  RC-062-17  35841
Public Aid Investigator  RC-062-17  35870
Public Aid Investigator Trainee  RC-062-14  35874
Public Aid Lead Casework Specialist  RC-062-17  35880
Public Aid Program Quality Analyst  RC-062-19  35890
Public Aid Quality Control Reviewer  RC-062-17  35892
Public Aid Staff Development Specialist I  RC-062-15  36071
Public Aid Staff Development Specialist II  RC-062-17  36072
Public Health Educator Associate  RC-062-14  36434
Public Health Program Specialist I  RC-062-14  36611
Public Health Program Specialist II  RC-062-16  36612
Public Health Program Specialist Trainee  RC-062-12  36615
Public Information Officer I  RC-062-12  37001
Public Information Officer II  RC-062-14  37002
Railroad Safety Specialist I  RC-062-19  37601
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

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## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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(Source: Amended at 27 Ill. Reg. 18560, effective December 1, 2003)
STATE BOARD OF EDUCATION
NOTICE OF ADOPTED AMENDMENTS

1) **Heading of the Part:** Standards for Certification in Specific Teaching Fields

2) **Code Citation:** 23 Ill. Adm. Code 27

3) **Section Numbers:**
   - 27.10 Amendment
   - 27.350 Amendment

4) **Statutory Authority:** 105 ILCS 5/2-3.6, 14C-8, and Art. 21

5) **Effective Date of Rulemaking:** December 1, 2003

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

7) **Does this rulemaking contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** April 4, 2003; 27 Ill. Reg. 5631

10) **Has JCAR issued a Statement of Objections to this rulemaking?** No

11) **Differences between proposal and final version:** One technical correction was made in the table of contents to the Part; the word “Section” was inserted preceding the list of Sections in Subpart B.

12) **Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** No changes were requested by JCAR, and no agreement letter was issued.

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

14) **Are there any amendments pending on this Part?** Yes

<table>
<thead>
<tr>
<th>Section</th>
<th>Action</th>
<th>Illinois Register Citation</th>
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<tr>
<td>27.460</td>
<td>Amendment</td>
<td>27 Ill. Reg. 17017; November 7, 2003</td>
</tr>
</tbody>
</table>

15) **Summary and Purpose of Amendments:** This set of standards has its origins in the determinations issued on June 22, 2000, by the Court-appointed Monitor in the *Corey H.* litigation. The Monitor’s determinations addressed necessary changes in Illinois...
certification policy with respect to both special education and general education teachers. The Monitor determined that, after content standards had been developed for general education teachers in the various subject fields, ISBE would be required to develop content-area standards related to the general curriculum for special education teachers as well.

These standards and indicators emphasize reading and mathematics but also include fundamental requirements in the natural and social sciences. They represent a synthesis of selected standards that are already in place with respect to elementary and special education as well as reading, mathematics, social science, and natural science. The guiding principle in their development was to state expectations for content knowledge that would enable special educators to afford their students access to the general curriculum as required by IDEA without unduly extending their preparation programs.

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

Lee Patton, Interim Director
Certification and Professional Development
Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777-0001
(217) 782-4123

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

TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER I: STATE BOARD OF EDUCATION
SUBCHAPTER b: PERSONNEL

PART 27
STANDARDS FOR CERTIFICATION IN SPECIFIC TEACHING FIELDS

SUBPART A: GENERAL

Section 27.10 Purpose and Effective Dates

SUBPART B: FUNDAMENTAL LEARNING AREAS

Section 27.100 English Language Arts
STATE BOARD OF EDUCATION

NOTICE OF ADOPTED AMENDMENTS

27.110 Reading
27.120 Reading Specialist
27.130 Mathematics
27.140 Science – A Common Core of Standards
27.150 Biology
27.160 Chemistry
27.170 Earth and Space Science
27.180 Environmental Science
27.190 Physics
27.200 Social Science – A Common Core of Standards
27.210 Economics
27.220 Geography
27.230 History
27.240 Political Science
27.250 Psychology
27.260 Sociology and Anthropology
27.270 Physical Education
27.280 Health Education
27.300 Dance
27.310 Drama/Theatre Arts
27.320 Music
27.330 Visual Arts
27.340 Foreign Language
27.350 General Curricular Standards for Special Education Teachers

SUBPART C: ADDITIONAL TEACHING FIELDS

Section
27.400 Agricultural Education
27.410 Business, Marketing, and Computer Education
27.420 English as a New Language (ENL)
27.430 Family and Consumer Sciences
27.440 Health Careers
27.450 Library Information Specialist
27.460 Technology Education
27.470 Technology Specialist
27.480 Work-Based Learning Teacher/Coordinator

AUTHORITY: Implementing Article 21 and authorized by Section 2-3.6 of the School Code [105 ILCS 5/Art. 21 and 2-3.6].
STATE BOARD OF EDUCATION
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SUBPART A: GENERAL

Section 27.10 Purpose and Effective Dates

This Part establishes the standards that, together with the standards set forth in Standards for All Illinois Teachers (see 23 Ill. Adm. Code 24), shall apply to the issuance of endorsements in specific teaching fields pursuant to Article 21 of the School Code [105 ILCS 5/Art. 21]. The standards set forth in this Part shall apply both to candidates for the respective endorsements and to the programs that prepare them. That is:

a) **except as provided in Section 27.350 of this Part**, beginning July 1, 2003, approval of any teacher preparation program or course of study in any field covered by this Part pursuant to the State Board's rules for Certification (23 Ill. Adm. Code 25, Subpart C) shall be based on the congruence of that program's or course's content with the standards identified in this Part; and

b) **except as provided in Section 27.350 of this Part**, beginning on July 1, 2004, the examination(s) required for issuance of a certificate endorsed in any field covered by this Part shall be based on the relevant standards set forth in this Part.

(Source: Amended at 27 Ill. Reg. 18586, effective December 1, 2003)

SUBPART B: FUNDAMENTAL LEARNING AREAS

Section 27.350 General Curricular Standards for Special Education Teachers

This Section establishes standards relative to the general curriculum that shall apply to the issuance of special education teaching endorsements pursuant to Article 21 of the School Code [105 ILCS 5/Art. 21]. The standards set forth in this Part shall apply both to candidates for the respective endorsements and to the programs that prepare them. Beginning July 1, 2005, approval of any teacher preparation program in special education shall be based on the congruence of that program’s or course’s content with the standards identified in this Section, and beginning on October 1, 2006, the examination(s) required for issuance of a special education teaching certificate shall cover the standards included in this Section.

a) **Mathematics**
The competent special education teacher demonstrates proficiency in the use of mathematics; understands, communicates, and connects the major concepts.
procedures, and reasoning processes of mathematics that define number systems and number sense, geometry, measurement, statistics, probability and algebra; and promotes all students' ability to apply, interpret, and construct mathematical thinking skills in a variety of situations.

1) Knowledge Indicators – The competent special education teacher:

A) understands various approaches used (estimation, mental mathematics, manipulative modeling, numerical/ geometric/algebraic pattern recognition, and technology) to analyze mathematical ideas, solve problems, and investigate real-world situations.

B) understands approaches used (estimation, mental mathematics, manipulative modeling, numerical/geometric/algebraic pattern recognition, and technology) to interpret and communicate mathematical information, reasoning, concepts, applications, and procedures.

C) understands concepts of math including numeration, geometry, measurement, statistics/probability, and algebra.

2) Performance Indicators – The competent special education teacher:

A) demonstrates proficiency in mathematics.

B) selects and uses a wide range of manipulatives, instructional resources, and technologies to support the learning of mathematics.

C) develops appropriate lesson plans that incorporate curriculum and instructional strategies with individualized education goals and benchmarks.

D) evaluates general curricula and determines the scope and sequence of the academic content area of mathematics.

E) utilizes resources and materials that are developmentally and functionally valid.
applies principles of instruction for generalized math skills to teaching domestic, community, school, recreational, or vocational skills that require mathematics.

plans and implements individualized, systematic instructional programs to teach priority mathematic skills.

incorporates the Illinois Learning Standards in areas of mathematics in the development of instruction and IEPs.

b) Reading
The competent special education teacher has a general understanding of reading and reading instruction and knows how to assess, teach, and support the education of students with disabilities.

1) Knowledge Indicators – The competent special education teacher:

A) knows theoretical models and philosophies of reading education and their relevance to instruction.

B) knows the scope and sequences for reading instruction at all developmental levels.

C) understands, respects, and values cultural, linguistic, and ethnic diversity and knows how these differences can influence learning to read.

D) understands the differences between reading skills and strategies and the role each plays in reading development.

E) knows a wide range of high-quality literature for students.

F) understands models of reading diagnosis that include students’ proficiency with print conventions, word recognition and analysis, vocabulary, fluency, comprehension, self-monitoring, and motivation.

G) knows a wide variety of informal and formal assessments of reading, writing, spelling, and oral language.
H) is aware of a variety of individualized and group instructional interventions or programs for students with reading problems.

I) plans and models the use of comprehension strategies across content areas.

2) Performance Indicators – The competent special education teacher:

A) adjusts reading instruction to meet the needs of diverse learners (e.g., gifted students, those for whom English is a second language, those with disabilities, and those who speak non-standard dialects).

B) locates, evaluates, and uses literature for readers of all abilities and ages.

C) uses various tools to estimate the readability of texts.

D) uses technology to support reading and writing instruction.

E) determines strengths and needs of individual students in the areas of reading, writing, and spelling.

F) determines students’ reading levels (independent, instructional, frustrational).

G) gathers and interprets information for diagnosis of the reading problems of individual students.

H) develops individual educational plans for students with severe learning problems related to literacy.

I) interprets and explains diagnostic information for classroom teachers, families, and other specialists to use in planning instructional programs.

J) designs, implements, and evaluates appropriate reading programs for small groups and individuals.

K) incorporates the Illinois Learning Standards in areas of reading in the development of instruction and IEPs.
c) Natural and Social Sciences
The competent special education teacher understands the fundamental concepts and principles related to the natural and social sciences.

1) Knowledge Indicators – The competent special education teacher:

A) understands scientific investigation and inquiry skills across the sciences to conduct experiments and solve problems.

B) understands principles and procedures, including safety practices, related to the design and implementation of scientific investigations and the application of inquiry skills and processes to develop explanations of natural phenomena.

C) understands the relationship among the social science disciplines.

D) understands that science is a process involving observation, inference, and experimentation.

E) understands the relationship between the social sciences and other learning areas.

2) Performance Indicators – The competent special education teacher:

A) demonstrates and uses appropriate strategies to engage students in acquiring new knowledge through the use of scientific thinking and reasoning.

B) selects and uses a wide range of instructional resources, modes of inquiry, and technologies to support learning in the natural and social sciences.

C) develops appropriate lesson plans that incorporate curriculum and instructional strategies with individualized education goals and benchmarks.

D) models the rights and responsibilities of citizenship in a democratic society.

E) models and teaches the appropriate use of scientific methods (e.g., gathering, organizing, mapping, interpreting, and analyzing).
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F) incorporates the Illinois Learning Standards in areas of natural and social science in the development of instruction and IEPs.

(Source: Added at 27 Ill. Reg. 18586, effective December 1, 2003)
ILLINOIS GAMING BOARD

NOTICE OF ADOPTED AMENDMENT

1) Heading of the Part: Riverboat Gambling

2) Code Citation: 86 Ill. Adm. Code 3000

3) Section Number: Adopted Action:
   3000.1071 Amended

4) Statutory Authority: Riverboat Gambling Act [230 ILCS 10]

5) Effective Date of Amendment: November 25, 2003

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

7) Does this proposed amendment contain incorporations by reference? No

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

9) Notice of Proposal Published in Illinois Register: July 11, 2002; 27 Ill. Reg. 10173

10) Has JCAR issued a Statement of Objection to this amendment? No

11) Differences between proposal and final version: None, except for nonsubstantive technical changes.

12) Have all of the changed agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this adopted amendment replace any emergency amendments currently in effect? Yes. Emergency amendments were adopted at 27 Ill. Reg. 10503, effective June 30, 2003, for no more than 150 days.

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

15) Summary and Purpose of Amendment: The General Assembly passed Senate Bills 1606 and 1607 on May 31, 2003. Senate Bill 1606 became Public Act 93-27 and Senate Bill 1607 became Public Act 93-28 upon approval by the Governor on June 20, 2003. Senate Bill 1606 amends Sections 13 of the Riverboat Gambling Act, 230 ILCS 10/13, to change the graduated wagering tax by riverboat gaming operations to the State of Illinois and to create the Common School Fund. Senate Bill 1608 amends Section 12 of the Act, 230 ILCS 10/12, to change the admission tax paid by riverboat gaming operations to a
graduated amount and creates an admission fee to be paid by license managers, as described in Section 7.3 of the Act, 230 ILCS 10/7.3.

16) Information and questions regarding this adopted amendment should be directed to:

Mark Ostrowski
Chief Counsel
Illinois Gaming Board
160 N. LaSalle, Suite 300-S
Chicago, Illinois 60601
312/814-4700
FAX 312/814-8798

The full text of the amendment begins on the next page:

TITLE 86: REVENUE
CHAPTER IV: ILLINOIS GAMING BOARD

PART 3000
RIVERBOAT GAMBLING

SUBPART A: GENERAL PROVISIONS

Section
3000.100 Definitions
3000.101 Invalidity
3000.102 Public Inquiries
3000.103 Organization of the Illinois Gaming Board
3000.104 Rulemaking Procedures
3000.105 Board Meetings
3000.110 Disciplinary Actions
3000.115 Records Retention
3000.120 Place to Submit Materials
3000.130 No Opinion or Approval of the Board
3000.140 Duty to Disclose Changes in Information
3000.141 Applicant/Licensee Disclosure of Agents
3000.150 Owner's and Supplier's Duty to Investigate
3000.155 Investigatory Proceedings
3000.160 Duty to Report Misconduct
3000.161 Communication with other Agencies
3000.165 Participation in Games by Owners, Directors, Officers, Key Persons or Gaming Employees
3000.170 Fair Market Value of Contracts
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3000.180 Weapons on Riverboat

SUBPART B: LICENSES

Section
3000.200 Classification of Licenses
3000.210 Fees and Bonds
3000.220 Applications
3000.221 Other Required Forms
3000.222 Identification and Requirements of Key Persons
3000.223 Disclosure of Ownership and Control
3000.224 Economic Disassociation
3000.225 Business Entity and Personal Disclosure Filings
3000.230 Owner's Licenses
3000.231 Distributions
3000.232 Undue Economic Concentration
3000.234 Acquisition of Ownership Interest By Institutional Investors
3000.235 Transferability of Ownership Interest
3000.236 Owner's License Renewal
3000.237 Renewed Owner's Licenses, Term and Restrictions
3000.238 Appointment of Receiver for an Owner's License
3000.240 Supplier's Licenses
3000.241 Renewal of Supplier's License
3000.242 Amendment to Supplier's Product List
3000.243 Bankruptcy or Change in Ownership of Supplier
3000.245 Occupational Licenses
3000.250 Transferability of Licenses
3000.260 Waiver of Requirements
3000.270 Certification and Registration of Electronic Gaming Devices
3000.271 Analysis of Questioned Electronic Gaming Devices
3000.280 Registration of All Gaming Devices
3000.281 Transfer of Registration (Repealed)
3000.282 Seizure of Gaming Devices (Repealed)
3000.283 Analysis of Questioned Electronic Gaming Devices (Repealed)
3000.284 Disposal of Gaming Devices

SUBPART C: OWNER'S INTERNAL CONTROL SYSTEM

Section
3000.300 General Requirements – Internal Control System
3000.310 Approval of Internal Control System
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3000.320 Minimum Standards for Internal Control Systems
3000.330 Review of Procedures (Repealed)
3000.340 Operating Procedures (Repealed)
3000.350 Modifications (Repealed)

SUBPART D: HEARINGS ON NOTICE OF DENIAL,
RESTRICION OF LICENSE OR PLACEMENT ON EXCLUSION LIST

Section
3000.400 Coverage of Subpart
3000.405 Requests for Hearings
3000.410 Appearances
3000.415 Discovery
3000.420 Motions for Summary Judgment
3000.424 Subpoena of Witnesses
3000.425 Proceedings
3000.430 Evidence
3000.431 Prohibition on Ex Parte Communication
3000.435 Sanctions and Penalties
3000.440 Transmittal of Record and Recommendation to the Board
3000.445 Status of Applicant for Licensure or Transfer Upon Filing Request for Hearing

SUBPART E: CRUISING

Section
3000.500 Riverboat Cruises
3000.510 Cancelled or Disrupted Cruises

SUBPART F: CONDUCT OF GAMING

Section
3000.600 Wagering Only with Approved Chips, Tokens and Electronic Cards
3000.602 Disposition of Unauthorized Winnings
3000.605 Authorized Games
3000.606 Gaming Positions
3000.610 Publication of Rules and Payout Ratio for Live Gaming Devices
3000.614 Tournaments, Enhanced Payouts and Give-aways
3000.615 Payout Percentage for Electronic Gaming Devices
3000.616 Cashing-In
3000.620 Submission of Chips for Review and Approval
3000.625 Chip Specifications
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3000.630 Primary, Secondary and Reserve Sets of Gaming Chips
3000.631 Tournament Chips
3000.635 Issuance and Use of Tokens for Gaming
3000.636 Distribution of Coupons for Complimentary Chips, Tokens and Cash
3000.640 Exchange of Chips and Tokens
3000.645 Receipt of Gaming Chips or Tokens from Manufacturer or Distributor
3000.650 Inventory of Chips
3000.655 Destruction of Chips and Tokens
3000.660 Minimum Standards for Electronic Gaming Devices
3000.665 Integrity of Electronic Gaming Devices
3000.666 Bill Validator Requirements
3000.670 Computer Monitoring Requirements of Electronic Gaming Devices

SUBPART G: EXCLUSION OF PERSONS

Section
3000.700 Duty to Exclude
3000.705 Voluntary Self-Exclusion Policy
3000.710 Distribution and Availability of Exclusion Lists
3000.720 Criteria for Exclusion or Ejection and Placement on an Exclusion List
3000.725 Duty of Licensees
3000.730 Procedure for Entry of Names
3000.740 Petition for Removal from Exclusion List
3000.750 Establishment of an Self-Exclusion List
3000.751 Locations to Execute Self-Exclusion Forms
3000.755 Information Required for Placement on the Self-Exclusion List
3000.756 Stipulated Sanctions for Failure to Adhere to Voluntary Self-Exclusion
3000.760 Distribution and Availability of Confidential Self-Exclusion List
3000.770 Duties of Owner Licensees
3000.780 Request for Removal from the IGB Self-Exclusion List
3000.785 Appeal of a Notice of Denial of Removal
3000.790 Duties of the Board

SUBPART H: SURVEILLANCE AND SECURITY

Section
3000.800 Required Surveillance Equipment
3000.810 Riverboat and Board Surveillance Room Requirements
3000.820 Segregated Telephone Communication
3000.830 Surveillance Logs
3000.840 Storage and Retrieval
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3000.850 Dock Site Board Facility
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SUBPART I: LIQUOR LICENSES

Section
3000.900 Liquor Control Commission
3000.910 Liquor Licenses
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SUBPART J: OWNERSHIP AND ACCOUNTING RECORDS AND PROCEDURES

Section
3000.1000 Ownership Records
3000.1010 Accounting Records
3000.1020 Standard Financial and Statistical Records
3000.1030 Annual and Special Audits and Other Reporting Requirements
3000.1040 Accounting Controls Within the Cashier's Cage
3000.1050 Procedures for Exchange of Checks Submitted by Gaming Patrons and Granting Credit
3000.1060 Handling of Cash at Gaming Tables
3000.1070 Tips or Gratuities
3000.1071 Admission Tax and Wagering Tax
3000.1072 Cash Reserve Requirements

SUBPART K: SEIZURE AND DISCIPLINARY HEARINGS

Section
3000.1100 Coverage of Subpart
3000.1105 Duty to Maintain Suitability
3000.1110 Board Action Against License or Licensee
3000.1115 Complaint
3000.1120 Appearances
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3000.1126 Appointment of Hearing Officer
3000.1130 Discovery
3000.1135 Motions for Summary Disposition
3000.1139 Subpoena of Witnesses
3000.1140 Proceedings
3000.1145 Evidence
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3000.1146 Prohibition of Ex Parte Communication
3000.1150 Sanctions and Penalties
3000.1155 Transmittal of Record and Recommendation to the Board

AUTHORITY: Implementing and authorized by the Riverboat Gambling Act [230 ILCS 10].


SUBPART J: OWNERSHIP AND ACCOUNTING RECORDS AND PROCEDURES

Section 3000.1071 Admission Tax and Wagering Tax

a) Each holder of an Owner's license ("licensor") and licensed manager ("manager") is subject to tax and fee liability assessment for each Gaming Day for the Admission Tax, Admission Fee and the Wagering Tax as imposed under the Act.

b) Admission Taxes and Fees and Wagering Taxes shall be paid via an electronic funds transfer system employing an Automated Clearinghouse Debit method (ACH-Debit). Each licensee and manager shall maintain an account with sufficient funds to pay, in a timely fashion, all tax and fee liabilities due under the Act. The account shall be maintained at a financial institution capable of making
c) Admission **Taxes and Fees** and Wagering Tax liability shall be established on the basis of a Gaming Day. Each licensee and manager shall select, with the approval of the Administrator, a 24 hour cycle to be defined as the uniform Gaming Day for that licensee or manager. A Gaming Day may begin on one calendar day and end the next calendar day, provided that the Gaming Day does not extend beyond the uniform 24 hour period selected in advance by the licensee or manager.

d) The Administrator shall prescribe and make available to each licensee and manager forms, instructions and reporting requirements for Admission **Taxes and Fees** and Wagering Taxes. The required forms include the Daily Tax and Fee Schedules. The Daily Tax and Fee Schedules may be provided by the Administrator to licensees and managers in computer-based format and include a computer program that, upon input by the licensee and manager of requisite data, provides for the calculation of tax and fee reporting information and tax and fee liability. Daily Tax and Fee Schedules shall be completed for each Gaming Day. The monthly float adjustment shall be completed on the Daily Tax and Fee Schedule for the final Gaming Day of each month.

e) The Daily Tax and Fee Schedules must be filed with the Board no later than 12:00 noon on the Due Date. Admission **Taxes and Fees** and Wagering Tax payments shall be transferred electronically on the Due Date to the Board's designated financial institution by the end of that financial institution's business day. For purposes of tax and fee schedules and tax and fee payments, the Due Date shall be defined as one bank business day after the close of the Gaming Day for which the liability is established. For example, if the Gaming Day of a licensee or manager ends at 2:00 a.m. on a Tuesday (i.e., the end of a Gaming Day that began on Monday), the Due Date is the Wednesday which follows, unless that Wednesday is not a bank business day, in which case the subsequent bank business day is the Due Date.

f) The Admission Tax for a Gaming Day shall be calculated and imposed as provided in Section 12 of the Act. *Until July 1, 2002, the rate is $2 per person admitted. From Beginning July 1, 2002 until July 1, 2003, the rate is $3 per person admitted. Beginning July 1, 2003, for a licensee that admitted 1,000,000 persons or fewer in the previous calendar year, the rate is $3 per person admitted; for a licensee that admitted more than 1,000,000 but no more than 2,300,000 persons in the previous calendar year, the rate is $4 per person admitted; and for a licensee that admitted more than 2,300,000 persons in the*
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previous calendar year, the rate is $5 per person admitted. This admission tax is imposed upon the licensed owner conducting gambling. The admission tax shall be paid for each admission. [230 ILCS 10/12(a)]

The Admission Fee for a Gaming Day shall be calculated and imposed as provided in Section 12 of the Act. For a licensee that admitted 1,000,000 persons or fewer in the previous calendar year, the rate is $3 per person admitted; for a licensee that admitted more than 1,000,000 but no more than 2,300,000 persons in the previous calendar year, the rate is $4 per person admitted; and for a licensee that admitted more than 2,300,000 persons in the previous calendar year, the rate is $5 per person admitted. [230 ILCS 10/12(a-5)]

For any Gaming Day that commences after December 31, 1997 and ends on July 1, 2002, the Wagering Tax imposed on the licensee shall be based on each calendar year's accumulated Adjusted Gross Receipts and calculated at the following graduated rates:

1) 15% of the calendar year Adjusted Gross Receipts up to and including $25,000,000;

2) 20% of the calendar year Adjusted Gross Receipts in excess of $25,000,000 but not exceeding $50,000,000;

3) 25% of the calendar year Adjusted Gross Receipts in excess of $50,000,000 but not exceeding $75,000,000;

4) 30% of the calendar year Adjusted Gross Receipts in excess of $75,000,000 but not exceeding $100,000,000; and

5) 35% of the calendar year Adjusted Gross Receipts in excess of $100,000,000.

For any Gaming Day that commences on or after July 1, 2002 and ends on July 1, 2003, the Wagering Tax imposed on the licensee shall be based on each calendar year's accumulated Adjusted Gross Receipts and calculated at the following graduated rates:
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1) 15% of the calendar year Adjusted Gross Receipts up to and including $25,000,000;

2) 22.5% of the calendar year Adjusted Gross Receipts in excess of $25,000,000 but not exceeding $50,000,000;

3) 27.5% of the calendar year Adjusted Gross Receipts in excess of $50,000,000 but not exceeding $75,000,000;

4) 32.5% of the calendar year Adjusted Gross Receipts in excess of $75,000,000 but not exceeding $100,000,000;

5) 37.5% of the calendar year Adjusted Gross Receipts in excess of $100,000,000 but not exceeding $150,000,000;

6) 45% of the calendar year Adjusted Gross Receipts in excess of $150,000,000 but not exceeding $200,000,000; and

7) 50% of the calendar year Adjusted Gross Receipts in excess of $200,000,000.

j) For any Gaming Day that commences on or after July 1, 2003, the Wagering Tax imposed on the licensee shall be based on each calendar year’s accumulated Adjusted Gross Receipts and calculated at the following graduated rates:

1) 15% of the calendar year Adjusted Gross Receipts up to and including $25,000,000;

2) 27.5% of the calendar year Adjusted Gross Receipts in excess of $25,000,000 but not exceeding $37,500,000;

3) 32.5% of the calendar year Adjusted Gross Receipts in excess of $37,500,000 but not exceeding $50,000,000;

4) 37.5% of the calendar year Adjusted Gross Receipts in excess of $50,000,000 but not exceeding $75,000,000;

5) 45% of the calendar year Adjusted Gross Receipts in excess of $75,000,000 but not exceeding $100,000,000;

6) 50% of the calendar year Adjusted Gross Receipts in excess of $100,000,000.
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$100,000,000 but not exceeding $250,000,000; and

7) 70% of the calendar year Adjusted Gross Receipts in excess of $250,000,000.

k) The Wagering Tax imposed under subsection (j) shall no longer be imposed beginning the earlier of:

1) July 1, 2005;

2) the first date after July 1, 2003 that riverboat gambling operations are conducted pursuant to a non-operating or dormant license; or

3) the first day that riverboat gambling operations are conducted under the authority of an Owner's license that is in addition to the 10 Owner's licenses initially authorized under Section 7 of the Act.

l) Beginning on the first day on which the tax imposed under subsection (j) is no longer imposed, a privilege tax is imposed on persons engaged in the business of conducting riverboat gambling operations, based on the Adjusted Gross Receipts received by a licensed owner from gambling games authorized under the Act at the following rates:

1) 15% of annual Adjusted Gross Receipts up to and including $25,000,000; 

2) 22.5% of annual Adjusted Gross Receipts in excess of $25,000,000 but not exceeding $50,000,000; 

3) 27.5% of annual Adjusted Gross Receipts in excess of $50,000,000 but not exceeding $75,000,000; 

4) 32.5% of annual Adjusted Gross Receipts in excess of $75,000,000 but not exceeding $100,000,000; 

5) 37.5% of annual Adjusted Gross Receipts in excess of $100,000,000 but not exceeding $150,000,000; 

6) 45% of annual Adjusted Gross Receipts in excess of $150,000,000 but not exceeding $200,000,000; 

7) 50% of annual Adjusted Gross Receipts in excess of $200,000,000.
m) Riverboat gambling operations conducted by a manager on behalf of the State are not subject to the Wagering Tax imposed under Section 13 of the Act.

n) Daily Tax and Fee Schedules shall include all information necessary for adjustments and reconciliation of tax and fee liability and shall be subject to audit by the Board and its audit agents. Adjustments to previously reported tax and fee information shall be made by the licensee, except that no adjustment of $25,000 or more shall be made to previously reported Adjusted Gross Receipts without the prior written approval of the Administrator or the Administrator's designee.

o) Any adjustment for a Gaming Day which commenced on or before December 31, 1997, shall be authorized by the Administrator or the Administrator's designee, and shall be taxed at a rate of 20% of Adjusted Gross Receipts. Any adjustment for a Gaming Day that commences after December 31, 1997, shall be taxed at the graduated tax or fee rate applicable to the Gaming Day upon which the adjustment is effected.

p) In the event that a Daily Tax and Fee Schedule for a specific Gaming Day properly reflects a net wagering loss experienced by the licensee or manager, an adjustment for the amount of any remaining net wagering loss (negative Adjusted Gross Receipts) shall be carried forward on the subsequent Daily Tax and Fee Schedules until such loss is offset by Gaming win (positive Adjusted Gross Receipts).

q) All Admission Taxes and Wagering Taxes paid pursuant to the requirements of the Act shall be deposited by the Board into the State Gaming Fund or Common School Fund. The Board shall determine the amount of excess funds subject to transfer to the Common School Fund based upon the addition to the amount of Wagering Taxes that would have been collected if the Wagering Tax rates under subsection (j) were not in effect. The Board shall determine the amount of excess funds subject to transfer based upon the difference between the State Gaming Fund balance and the outstanding obligations, including any outstanding share of Admission and Wagering Taxes due to local governments, the Horse Racing Equity Fund, a home rule county with a population over 3,000,000, and the Chicago State University Universities Athletic Capital Improvement Fund. The Administrator will be responsible for calculating the allocation of the Admission Taxes and Fees and Wagering Taxes between the State and the unit of local government designated as the home dock of the Riverboat and the other required allocations.
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as provided in the Act. Payments for Admission Taxes and Fees shall be made by the Board to units of local government quarterly, and payments for Wagering Taxes and all other payments, other than the Common School Fund, shall be made monthly, by voucher/warrant, subject to appropriation.

A licensee's or manager's failure to comply with the provisions of this Section may subject the licensee or manager to penalty and interest amounts pursuant to the Uniform Penalty and Interest Act [35 ILCS 735]. The Administrator is authorized to waive any penalty and interest for the late filing of a tax schedule or late tax payment, if the licensee or manager can show good cause. "Good cause" shall include, but not be limited to, detection and correction of a deficiency in filing or payment that resulted from a documented inadvertent or unintentional error that was corrected within one business day after the applicable Due Date. The licensee or manager shall be notified by the Administrator in writing of any penalty or interest payable because of a late tax schedule filing or late tax payment. The licensee or manager may, within 10 business days after receiving the notice, file a written request for a waiver with the Administrator. The Administrator shall act on the request for waiver and notify the licensee or manager in writing of the decision within 15 calendar days after receiving the request. If the Administrator fails to act within the 15 day period the waiver is deemed granted. If the Administrator denies the request for waiver the licensee or manager may ask the Board for a hearing. The request for hearing must be in writing and filed not later than 15 calendar days after receipt of the notice of denial. Except as provided in this subsection (r)(m), the provisions for hearings under Subpart D shall apply to any hearing conducted under this Section. A hearing under this Section is not a disciplinary hearing under Subpart K of this Part.

(Source: Amended at 27 Ill. Reg. 18595, effective November 25, 2003)
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1) **Heading of the Part:** Medical Assistance Programs

2) **Code Citation:** 89 Ill. Adm. Code 120

3) **Section Numbers:**
   - 120.32 Amendment
   - 120.520 Amendment

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-63

5) **Effective Date of Amendments:** November 26, 2003

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

7) **Do these amendments contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 18, 2003 (27 Ill. Reg. 10628)

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

11) **Differences Between Proposal and Final Version:** No substantive changes have been made.

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 these amendments replace emergency amendments currently in effect?** Yes

14) **Are there any other amendments pending on this Part?** Yes

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15) **Summary and Purpose of Amendments:** These amendments provide for eligibility expansion for the KidCare Parent Coverage Waiver program (FamilyCare). Under Public Act 93-63, the FamilyCare income eligibility standard for parents and other adult
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

caretaker relatives is being raised to 90 percent of the Federal Poverty Income Guidelines.

Section 120.520

Amendments regarding SeniorCare pharmaceutical benefits provide technical clarifications that align Section 120.520 with the Department's operational policies. Concerning eligibility for SeniorCare, subsection (a) specifies that an individual must be a U.S. citizen or qualify as an eligible non-citizen as described at Section 120.310. On termination of SeniorCare coverage, subsection (j)(5) is being revised to include discovery that the initial determination of eligibility was incorrect, as a termination determinant. These changes coordinate with companion amendments concerning SeniorCare that are being adopted at 89 Ill. Adm. Code 140.405 to eliminate the processing of SeniorCare claims by an outside contractor.

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

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

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

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120
MEDICAL ASSISTANCE PROGRAMS

SUBPART A: GENERAL PROVISIONS

Section 120.1 Incorporation by Reference

SUBPART B: ASSISTANCE STANDARDS

Section
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120.10 Eligibility For Medical Assistance
120.11 MANG(P) Eligibility
120.12 Healthy Start – Medicaid Presumptive Eligibility Program For Pregnant Women
120.20 MANG(AABD) Income Standard
120.30 MANG(C) Income Standard
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120.32 KidCare Parent Coverage Waiver Eligibility and Income Standard
120.40 Exceptions To Use Of MANG Income Standard
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Section
120.60 Cases Other Than Long Term Care, Pregnant Women and Certain Children
120.61 Cases in Intermediate Care, Skilled Nursing Care and DMHDD – MANG(AABD) and All Other Licensed Medical Facilities
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120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings
120.64 MANG(P) Cases
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SUBPART E: RECIPIENT RESTRICTION PROGRAM

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120.500  Health Benefits for Persons with Breast or Cervical Cancer
120.510  Health Benefits for Workers with Disabilities
120.520  SeniorCare

120.TABLE A  Value of a Life Estate and Remainder Interest
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SUBPART B: ASSISTANCE STANDARDS

Section 120.32 KidCare Parent Coverage Waiver Eligibility and Income Standard

a) A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard and all MANG(C) eligibility requirements in this Part, with the exception of Sections 120.320 through 120.323, are met.

b) The appropriate income standard is 90% of the Federal Poverty Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

c) If income is greater than this amount, it is compared to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.

(Source: Amended at 27 Ill. Reg. 18609, effective November 26, 2003)

SUBPART I: SPECIAL PROGRAMS
Section 120.520 SeniorCare

a) To be eligible for SeniorCare pharmaceutical benefits as set forth at 89 Ill. Adm. Code 140.405, an individual must meet all of the following eligibility requirements:

1) Be a U.S. citizen or qualify as an eligible non-citizen pursuant to Section 120.310 an immigrant admitted for permanent residence.

2) Reside in Illinois.

3) Be 65 years of age or older.

4) Assign rights to medical support and collection of payments as described in Section 120.319.

5) Furnish his or her Social Security Number.

6) Have countable annual income at or below 200 percent of the poverty guidelines published annually by the U.S. Department of Health and Human Services.

b) The earned and unearned income of the applicant and his or her spouse (if the spouse resides with the applicant) shall be counted when determining eligibility, except that the following shall not be counted:

1) cash gifts;

2) child support payments;

3) Circuit Breaker grants;

4) damages awarded from a lawsuit for a physical personal injury or sickness;

5) Energy Assistance payments;

6) federal income tax refunds;

7) IRAs "rolled over" into other retirement accounts;
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8) lump sums from inheritances;
9) lump sums from insurance policies;
10) money borrowed against a life insurance policy;
11) reverse mortgage income;
12) stipends from the Foster Parent and Foster Grandparent programs; and
13) Worker's Compensation.

c) Assets shall not be considered.

d) SeniorCare participants shall be exempt from the requirements of 89 Ill. Adm. Code 102.210, Estate Claims, with regard to expenditures made for SeniorCare benefits.

e) An individual who is eligible for medical assistance with a spenddown may participate in SeniorCare.

f) An individual who receives benefits from any of the Medicare Savings programs (QMB, SLIB, or QI) may participate in SeniorCare.

g) Application Process

1) Individuals shall apply by completing and submitting an application as specified by the Illinois Department of Revenue.

2) Spouses may apply on the same application as long as the application contains both signatures.

3) After eligibility is determined by the Illinois Department of Revenue, notice of the outcome shall be sent to the applicant.

4) An individual enrolled in SeniorCare shall receive coverage under his or her own name and unique Recipient Identification Social Security Number.
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h) Enrollment Periods

1) Enrollment shall be effective no later than one month after the date when the applicant was determined to be eligible for the program.

2) An individual who first enrolls in SeniorCare between July 1 and December 31 of any year shall be enrolled through the end of that State fiscal year. For example, an individual who first enrolls on December 1, 2002, shall be eligible through June 30, 2003.

3) An individual who first enrolls in SeniorCare between January 1 and June 30 of any year shall be enrolled through the end of that fiscal year plus all of the following fiscal year. For example, an individual who first enrolls on January 1, 2003, shall be eligible through June 30, 2004.

4) Individuals must reapply annually.

5) Subsequent uninterrupted periods of enrollment shall be for 12 months and shall be coincident with the State fiscal year.

i) Authorization of SeniorCare

1) Once an individual has been determined eligible for SeniorCare, a SeniorCare identification card shall be sent to the individual.

2) Upon receipt of the card, the participant shall have the option of receiving a SeniorCare Rebate as established in 89 Ill. Adm. Code 140.405 instead of using the SeniorCare card. **Enrollment in the SeniorCare Rebate option shall be effective prospectively for the month following the month in which the individual is approved for SeniorCare Rebate.**

j) SeniorCare coverage shall terminate:

1) at the end of a participant's enrollment period unless the participant reenrolls timely and is found to continue to be eligible;

2) when a participant no longer resides in Illinois;

3) when a participant becomes an inmate of a public institution as set forth in 42 CFR 435.1008; **of**
DEPARTMENT OF PUBLIC AID

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4) upon a participant's death; or-

5) upon discovery that the initial determination of the participant's eligibility was incorrect.

k) Individuals applying for or enrolled in SeniorCare shall be entitled to appeal rights as described at 89 Ill. Adm. Code 102.80.

(Source: Amended at 27 Ill. Reg. 18609, effective November 26, 2003)
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## NOTICE OF ADOPTED AMENDMENTS

1. **Heading of the Part:** Children’s Health Insurance Program
2. **Code Citation:** 89 Ill. Adm. Code 125
3. **Section Numbers:**
   - 125.200 Amendment
   - 125.240 Amendment
4. **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-0063
5. **Effective Date of Amendments:** November 26, 2003
6. **Does this rulemaking contain an automatic repeal date?** No
7. **Do these amendments contain incorporations by reference?** No
8. A copy of the adopted amendments, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
9. **Notice of Proposal Published in Illinois Register:** July 18, 2003; 27 Ill. Reg. 10631
10. **Has JCAR issued a Statement of Objections to these amendments?** No
11. **Differences Between Proposal and Final Version:** No changes have been made to the proposed amendments.
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 these amendments replace emergency amendments currently in effect?** Yes
14. **Are there any other amendments pending on this Part?** No
15. **Summary and Purpose of Amendments:** These amendments provide for eligibility expansion for the Children's Health Insurance Program (KidCare). Under Public Act 93-0063, the income eligibility standard will be raised to 200 percent of the Federal Poverty Income Guidelines.
16. **Information and questions regarding these adopted amendments shall be directed to:**
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

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

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

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 125
CHILDREN'S HEALTH INSURANCE PROGRAM

SUBPART A: GENERAL PROVISIONS

Section
125.100 General Description
125.110 Definitions

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section
125.200 Eligibility for Children's Health Insurance Program
125.205 Eligibility Exclusions and Terminations
125.220 Application Process
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SUBPART C: KIDCARE HEALTH PLAN

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125.300 Covered Services
125.305 Service Exclusions
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125.320 Premium Requirements
125.330 Non-payment of Premium
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SUBPART D: KIDCARE REBATE

Section
125.400 Minimum Coverage Requirements
125.420 Coverage Verification Process
125.430 Provision of Policyholder's Social Security Number
125.440 KidCare Insurance Rebate
125.445 Rebate Overpayments

AUTHORITY: Implementing and authorized by the Children's Health Insurance Program Act [215 ILCS 106] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].


SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 125.200 Eligibility for Children's Health Insurance Program

A child may be eligible under the Program provided that all of the following eligibility criteria are met:

a) The child is not eligible for Medical Assistance.

b) The child is under 19 years of age.

c) The child is a member of a Family whose monthly countable income is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level.
DEPARTMENT OF PUBLIC AID

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d) The child is a resident of the State of Illinois.

e) The child is either a United States citizen or included in one of the following categories of non-citizens:

1) Unmarried dependent children of either a United States veteran honorably discharged or a person on active military duty.

2) Refugees under Section 207 of the Immigration and Nationality Act.

3) Asylees under Section 208 of the Immigration and Nationality Act.

4) Persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act.

5) Persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

6) Persons lawfully admitted for permanent residence under the Immigration and Nationality Act.

7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

f) The child's Social Security Number (SSN) is provided to the Department, or if it has not been issued or is not known, proof that application has been made for an SSN is provided.

(Source: Amended at 27 Ill. Reg. 18623, effective November 26, 2003)

Section 125.240 Eligibility Determination and Enrollment Process

a) If the monthly countable income is at or below 133 percent of the Federal Poverty Level for the number of persons in the Family, the child will be enrolled in Medical Assistance, if otherwise determined eligible pursuant to 89 Ill. Adm. Code 120, Subpart H.

b) If the monthly countable income is above 133 percent and at or below 200 percent of the Federal Poverty Level for the number of persons in the Family, and all other eligibility requirements of this Part are met and enrollment is open, the
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child will be enrolled in the Program.

c) For purposes of cost sharing, Families in the KidCare Health Plan will be enrolled into either KidCare Share or KidCare Premium as follows:

1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level for the number of persons in the Family, the child will be enrolled in KidCare Share.

2) If monthly countable income is above 150 percent and at or below 200 percent of the Federal Poverty Level for the number of persons in the Family, the child will be enrolled in KidCare Premium.

d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

e) Eligibility determinations for the Program made by the fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the Program made after the fifteenth day of the month will be effective no later than the first day of the second month following that determination.

f) The duration of eligibility for the Program will be 12 months unless one of the events described in Section 125.205(c) occurs. The 12 months of eligibility will commence when the first child in a Family is covered under the Program. Children added to the Program after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.

g) Children determined to be eligible for the KidCare Health Plan may obtain coverage for a period prior to the date of application for the Program. This coverage shall be subject to the following:

1) The Family must request the prior coverage for the child within six months following the initial date of coverage under the KidCare Health Plan.

2) The prior coverage will be child specific and will only be available the first time the child is enrolled in the Program.

3) The prior coverage will begin with services rendered during the two weeks prior to the date the child's application for the KidCare Health Plan was
DEPARTMENT OF PUBLIC AID

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filed and will continue until the child's coverage under the KidCare Health Plan is effective pursuant to Section 125.240(e).

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)
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1) **Heading of the Part:** Medical Payment

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

3) **Section Numbers:**
   - 140.402 Amendment
   - 140.405 Amendment
   - 140.464 Amendment
   - 140.471 Amendment
   - 140.472 Amendment
   - 140.474 Amendment
   - 140.481 Amendment
   - 140.493 Amendment
   - 140.523 Amendment
   - 140.551 Amendment
   - 140.553 Amendment
   - 140.554 Repeal
   - 140.700 Amendment
   - 140.830 Amendment
   - 140.930 Amendment

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

5) **Effective Date of Amendments:** November 26, 2003

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

7) **Do these amendments contain incorporations by reference?** Yes

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

9) **Notice of Proposal Published in Illinois Register:**

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

11) **Differences Between Proposal and Final Version:**

    *Sections 140.402 – 140.930*
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Section 140.492

Section 140.492 has been deleted from the proposed rulemaking. Following publication of the proposed rulemaking on July 18, 2003 (27 Ill. Reg. 10633), circumstances arose in which the Department found it necessary to implement emergency changes to Section 140.492 on September 20, 2003 (27 Ill. Reg. 15584). Identical proposed amendments were published on September 19, 2003 (27 Ill. Reg. 14776) to meet federal public notice requirements. These new rulemakings reflect all currently applicable changes for Section 140.492. Therefore, the earlier proposed amendments to Section 140.492 are no longer relevant or necessary.

Section 140.551

In the description of “General Service costs”, the term “mostly” has been stricken.

Sections 140.551 and 140.553

Incorporation by reference information has been added after “...nursing home costs,” which reads, “(Health Care Cost Review, a publication of the Cost Information Forecasting Service, published quarterly by DRI-WEFA, Inc., a Global Insight Company, 24 Hartwell Avenue, Lexington, Massachusetts 02421 (2001). This incorporation by reference does not include any later amendments or editions.”

Section 140.830

In subsection (a), “their rates” has been changed to “their support and capital rates”, and “, effective July 1, 1984,” has been stricken. Also, for the text, “Appeals of rate determinations shall be submitted in writing to the Department.”, the striking has been removed and the text is being retained in the rule.

The beginning of subsection (b) has been revised to read: “The Department shall notify all nursing facilities of their nursing rate no later than 30 days before the beginning of the rate quarter pursuant to 89 Ill. Adm. Code 147.150. Appeals shall be submitted to the Department no later than . . .”.

Sections 140.471, 140.472 and 140.474

Section 140.472
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A new subsection (c) has been added which reads “Nursing agencies may provide covered services for which they are certified by the University of Illinois, Division of Specialized Care for Children, to individuals under the age of 21 years.”

The previous subsection (c) has been relabeled as subsection (d).

For the previous subsection (d), the label and the existing text have been stricken and the new text has been deleted.

Section 140.474

In subsection (a)(3), the stricken text has been returned to the rule.

In subsection (b), the new text has been deleted and the remaining text has been stricken.

Subsection (c) has been relabeled as subsection (b).

No other substantive changes have been made in the text of the proposed amendments.

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 these amendments replace emergency amendments currently in effect?

Sections 140.402 – 140.930 – Yes

Sections 140.471, 140.472 and 140.474 - No

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

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15) Summary and Purpose of Amendments:
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Sections 140.402 – 140-930

These amendments respond to Public Act 92-848 regarding a new rate methodology for Medicaid funded nursing facilities, and to Public Act 93-20 regarding fiscal year 2004 budget implementation. These latter changes pertain to copayments for drugs, SeniorCare, clinic services, medical equipment and transportation, and bedreserve payments for nursing facilities. Following are descriptions of the specific changes.

Section 140.402 - The copayment for generic prescription drugs is being eliminated.

Section 140.405 - These changes eliminate the services of the pharmacy benefit manager in administering the SeniorCare pharmaceutical program. Program administration will be brought in-house to save the administrative costs of a third-party contractor. These changes are necessary to make reimbursement changes compatible with in-house handling of claims processing.

Sections 140.464 and 140.930 - Provisions concerning hospital-based and encounter rate clinics in Section 140.463 were mistakenly stricken from the Department's rules on March 15, 2002. These necessary provisions have been updated and are being returned to the rules at Section 140.464. Related changes are being made at Section 140.930 to update pertinent cross-references.

Sections 140.481 and 140.493 - These changes maintain rates in effect on June 30, 2003, for durable medical equipment and medical transportation, including helicopter transportation.

Sections 140.523 and 140.700 - Under these changes, the Department will no longer reimburse nursing facilities to hold a bed while a resident is temporarily out of the facility for a hospitalization. However, the Nursing Home Care Act will continue to require nursing facilities to hold a bed for up to ten days per resident hospitalization. Related changes are being made regarding resident discharge.

Sections 140.551, 140.553, 140.554 and 140.830 - Pursuant to Public Act 92-848, the Department is establishing a new methodology for the nursing component of rates for Medicaid funded nursing facilities (NFs). For the nursing component, the Department will use the Minimum Data Set (MDS), a federally required assessment form, to collect information from NFs on the condition of residents and establish a rate based on all Medicaid residents in the NF. The nursing component will be calculated and adjusted on a quarterly basis.
Under the Act, The Department has developed the new rate methodology for which new payments are subject to appropriation levels provided by the General Assembly. Any increases will only be effective if specific appropriation is made for this purpose. A transition period of two years, beginning July 1, 2003, will be provided for initial implementation of the new payment methodology. During this period, for an NF that would receive a lower nursing component rate under the new system than under the current system, the nursing component rate will be held at the current rate until a higher rate is achieved by that NF.

If there is no specific appropriation for this purpose, there is no annual budgetary impact resulting from these proposed rate changes. Public Act 92-0848 states that rates under the new methodology shall be adjusted subject to appropriations provided by the General Assembly. If and when monies are made available, they will be distributed first to restore the 5.9% reduction from fiscal year 2003, then to distribute monies according to the new methodology. Nothing in these amendments should be construed as suggesting that these new monies are currently available or will be made available at any point in the future.

Sections 140.471, 140.472 and 140.474

These amendments make several changes concerning home health services which are covered on a short term basis for clients in their homes.

Section 140.471 - The term "homebound" is being stricken because home health coverage is not restricted to only homebound persons. "Residence" is defined as not including a hospital or long term care facility except that a resident of an ICF/MR (Intermediate Care Facility for the Mentally Retarded) may be covered for necessary home health services to the extent that those services are not provided for under 89 Ill. Adm. Code 144 (Developmental Disabilities Services).

Section 140.472 - Updating is provided by adding the "Nurse and Advanced Practice Nursing Act [225 ILCS 65]". Provisions allowing independent therapists to provide home health services are being stricken because such services are more cost effective when provided by therapists who are employed by home health agencies.

Section 140.474 - These cost containment changes allow payment for home health services for wards of the Department of Children and Family Services to be made at the Department's established rates, rather than negotiated on an individual patient basis.

Information and questions regarding these adopted amendments shall be directed to:
DEPARTMENT OF PUBLIC AID

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

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

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

PART 140
MEDICAL PAYMENT

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SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.402 Copayments for Noninstitutional Medical Services

a) Effective July 1, 2003, each recipient, with the exception of those classes of
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Recipients identified in subsection (d) of this Section, may be required to pay the following specified copayment for noninstitutional medical services:

1) Each office visit to a chiropractor, podiatrist, optometrist, or a physician licensed to practice medicine in all its branches billed to the Department, with the exception of those office visits for services identified in subsection (e) of this Section, may require a copayment of $2.00.

2) Each brand name legend drug billed to the Department, with the exception of drugs identified in subsection (e) of this Section, may require a copayment of $3.00. 3) Each generic legend drug billed to the Department, with the exception of drugs identified in subsection (e) of this Section, may require a copayment of $1.00.

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) of this Section 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) of this Section:

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

2) Children under 19 years of age.

3) All noninstitutionalized 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 mentally retarded.

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).

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

1) Renal dialysis treatment.
2) Radiation therapy.
3) Cancer chemotherapy.
4) Use of insulin.
5) Services for which Medicare is the primary payer.
6) Over-the-counter drugs.
7) Emergency services as defined at 42 CFR 447.53(b)(4).
8) Any pharmacy compounded drugs.
9) Any prescription (legend drug) dispensed or administered by a hospital, clinic or physician.
10) Family planning services.
11) Other therapeutic drug classes as specified by the Department.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.405 SeniorCare Pharmaceutical Benefit

a) Definitions. For purposes of this Section:

"Brand name drug" means those drugs as defined in Section 140.440(g)(3).

"FPL" means the federal poverty income guideline as determined annually by the
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United States Department of Health and Human Services.

"Generic drug" means those legend drugs as defined in Section 140.440(g)(2).

"Over-the-counter items" means those pharmaceutical items that may be purchased off the shelf by the general public, but for Medicaid-eligible individuals require a prescription.

"Pharmaceutical product" means a brand name drug, a generic drug, or an over-the-counter item.

"Reimbursable amount" means the price payable by the Department or its agent for a pharmaceutical product, as defined in subsection (e) of this Section.

"SeniorCare" means the provision of benefits to individuals qualifying for medical assistance under the provisions of 89 Ill. Adm. Code 120.520.

"SeniorCare benefit amount" means the cumulative sum of the reimbursable amounts for prescribed pharmaceutical products received by an individual eligible for SeniorCare during any State fiscal year.

"SeniorCare rebate" means a SeniorCare benefit in the form of a monetary payment (a monthly payment of $25) made to an individual enrolled in a third-party plan that provides a pharmacy benefit. The payment is made in lieu of the covered services described in this Section.

b) Covered Services

Except for an individual who elects to participate in the SeniorCare rebate program, covered services under the SeniorCare program shall consist of pharmaceutical products that are prescribed by licensed medical professionals authorized under State law to issue prescriptions within the scope of their professional practice, and subject to the provisions in Section 140.443.

c) Co-Payment

An individual eligible for SeniorCare benefits shall be responsible for payment of applicable co-payments. The co-payment for each brand name drug prescription or generic drug prescription is:

1) For an individual with a household income equal to or greater than the FPL, $1 for each dispensing of a generic drug and $4 for each dispensing
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of a brand name drug, in addition to any applicable co-payment under subsection (c)(2) of this Section.

2) For all individuals, 20 percent of the reimbursable amount for each prescription dispensed after the SeniorCare benefit amount has exceeded $1,750 for the State fiscal year. If any part of the cost is paid for by Medicare or another third party, the 20 percent is calculated on the net amount paid by the Department. Twenty percent of any reimbursable amount that, when added to the SeniorCare benefit amount, results in the SeniorCare benefit amount exceeding $1,750 during the State fiscal year.

3) On any prescription for which Medicare is the primary payer, the co-payments described in subsections (c)(1) and (2) of this Section do not apply.

d) Additional Payment
An individual eligible for SeniorCare benefits may be responsible for an additional payment to the pharmacy, as determined in subsection (e)(2) or (3) of this Section.

e) Reimbursable Amount

1) Except as provided in subsections (e)(2), and (3) and (4) of this Section, the reimbursable amount for a pharmaceutical product shall be:

A) For legend (prescription) drugs, the Department shall pay the lower of:

i) the pharmacy's prevailing charge to the general public; or

ii) the Department's maximum price plus a dispensing fee of $2.25 for both generic and brand name drugs less applicable co-payments as set forth in subsection (c) of this Section. The price arrived at using the applicable reimbursement methodology set forth in either Section 140.445 for legend prescription items or Section 140.446 for over-the-counter items; or

B) For generic drugs, the Department's maximum price is calculated as the lowest of:
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i) the average wholesale price minus 25 percent; or

ii) the Federal Upper Limit for drugs; or

iii) the State Upper Limit for drugs; or

iv) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

B) If the Department contracts with a third party to manage some portion of the SeniorCare program, the price established by the third-party contractor for its pharmacy network or the amount required to be paid to pharmacies by the Department's contract with the third-party.

C) For brand name drugs, the Department's maximum price is calculated as the lower of:

i) the average wholesale price minus 14 percent; or

ii) the average wholesale price for drugs where that price is based upon the actual market wholesale price.

D) For those over-the-counter items which are covered, the Department shall pay the lower of:

i) the prevailing charge to the general public; or

ii) the average wholesale price plus 25 percent.

2) If a generic drug is available, based upon the Illinois Formulary for Drug Product Selection Program (77 Ill. Adm. Code 790), and the individual wants the brand name version of the drug, the reimbursable amount shall be that of the generic drug unless the brand name drug is a federally defined narrow therapeutic index drug and substitution is not permitted because the prescribing practitioner has indicated "brand medically necessary" on the prescription. The co-payment amount shall be based upon the generic drug.

3) If a brand name drug is dispensed when the reimbursable amount is that
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for the generic drug, the individual shall be responsible for paying the difference between the reimbursable amount (based upon the generic drug) and what would have been the reimbursable amount for the brand name drug.

4) If the Department contracts with a third-party to manage some portion of the SeniorCare program, the reimbursable amount shall be the price established by the third party contractor for its pharmacy network or the amount required to be paid to pharmacies by the Department's contract with the third-party.

f) Provider Participation

In order to participate in the SeniorCare program, pharmacies shall meet the following requirements:

1) Prior to enrolling with the Department of Public Aid, the pharmacy must possess a current registration issued by the United States Drug Enforcement Administration (see 21 CFR 1301) and, if located in Illinois, a current controlled substances license issued by the Illinois Department of Professional Regulation (68 Ill. Adm. Code 1330) pursuant to the Illinois Controlled Substances Act [720 ILCS 570].

2) The pharmacy must be licensed as required by applicable State and federal laws and regulations.

3) The pharmacy must meet all enrollment criteria set forth by the Department of Public Aid and, if the Department contracts with a third-party to manage some portion of the SeniorCare program, agree to the terms required for participation in that third-party's pharmacy network.

4) The pharmacy must agree to comply with all applicable State and federal laws and regulations.

5) The pharmacy must agree to comply with all applicable Department of Public Aid policies and directives.

6) The pharmacy must agree not to limit prescriptions filled for individuals receiving care or services from the group practice or long term care facility to those written by practitioners connected with a group practice or long term care facility.
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7) If it is located in, or administratively associated with a group practice or long term care facility, the pharmacy must:

A) Provide the same scope of general pharmacy and professional services as does a pharmacy not so affiliated.

B) Be retail in nature and open and accessible to the general public.

8) A hospital pharmacy that provides pharmaceutical services and supplies for inpatients, outpatient clinic patients, or emergency room patients of the hospital shall not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (division V license).

g) Payment
Payment by the Department to a participating pharmacy for a pharmaceutical product dispensed to an individual eligible for SeniorCare shall be the difference of the reimbursable amount, as described in subsection (e) of this Section, less applicable co-payments, as described in subsection (c) of this Section, and any amount paid or payable by Medicare or another third-party as described in Section 140.12(h)(2).

h) SeniorCare Rebate
An individual eligible for SeniorCare who maintains coverage by a third-party plan that provides a pharmacy benefit may, at the time of application or reapplication, elect to participate in the SeniorCare rebate program. Individuals making that election shall receive a monthly payment of $25.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.464 Hospital-Based and Encounter Rate Clinic Payments Healthy Moms/Healthy Kids Managed Care Clinics (Repealed)

a) Hospital-Based Organized Clinics

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.
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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 women and infants, payment shall be made at the lesser of:

A) $75 per encounter; or

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

2) 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.

(Source: Section repealed at 20 Ill. Reg. 4345, effective March 4, 1996; new Section added at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.471 Home Health Covered Services

Short term, intermittent, home health services are provided for clients in their places of residence and are aimed at facilitating the transition from a more acute level of care to the home. Services provided shall be of a curative or rehabilitative nature and demonstrate progress toward short term goals outlined in a plan of care. Services shall be provided for homebound individuals upon direct order of a physician and in accordance with a plan of care established by the physician and reviewed at least every 60 days. For purposes of this Section, "residence" does not include a hospital or skilled nursing facility and only includes an intermediate care facility for the mentally retarded to the extent home health services are not required to be provided under 89 Ill. Adm. Code 144.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)
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Section 140.472 Types of Home Health Services

a) The types of services for which payment can be made are:

1) Skilled Nursing
2) Home Health Aid
3) Speech Therapy
4) Occupational Therapy
5) Physical Therapy

b) Home health agencies may provide covered services for which they are certified by Medicare or have been designated as Medicare certifiable by the Department of Public Health. In addition, they may provide medical equipment and appliances if it is the agency's usual and customary practice to provide such items as part of the per visit charge.

c) Nursing agencies may provide covered services for which they are certified by the University of Illinois, Division of Specialized Care for Children, to individuals under the age of 21 years.

d) In the absence of a qualified agency in the area, self-employed, registered nurses may provide nursing services within the scope of their practice, as defined by the Nursing and Advanced Practice Nursing Act [225 ILCS 65] Illinois Nurse Practice Act or, in other states, by comparable authority. Independent therapists may provide services for which they are qualified. Community health agencies may provide services for which they have been approved by the Department.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.474 Payment for Home Health Services

a) Except for subsection (b) of this Section, home health agencies shall be paid an all inclusive, per visit rate which shall be the lowest of:

1) the agency's usual and customary charge for the service;
2) the agency's Medicare rate; or

3) the Department's maximum allowable rate of $65.25. Beginning with the State fiscal year 2002, the maximum allowable rate may be adjusted annually in consideration of the appropriation of funds by the General Assembly.  

b) Payment for services for children whose care is subsidized by the Illinois Department of Children and Family Services shall be negotiated on an individual patient basis but shall be no greater than the agency's usual and customary charge to the general public.

c) Payment to self-employed registered nurses providing in-home nursing services is made at the community rate for such services as determined for each case at the time prior approval is given.

d) Payment to independent therapists and community health agencies shall be at the provider's usual and customary charge, not to exceed the maximum established by the Department.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.481 Payment for Medical Equipment, Supplies, Prosthetic Devices and Hearing Aids

a) Notwithstanding the provisions set forth in this Section, beginning for the period of July 1, 2002, through June 30, 2003, the reimbursement rates paid for medical equipment, supplies, prosthetic devices and hearing aids shall be the lesser of the provider's usual and customary charge to the general public or 94 percent of the fiscal year 2002 rate otherwise determined by the Department under this Section.

b) Payment for Medical Equipment. Medical equipment is durable, reusable equipment such as wheelchairs, hospital beds, canes, walkers, etc. Payment for medical equipment is made for covered items or services at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate established by the Department for each item of medical equipment is to be based on pricing for widely accepted quality items. The Department shall review and update the maximum allowable rate at least annually. Widely accepted quality items are items which are not below average quality for like medical equipment and which are available statewide. The maximum allowable rate established for each item or service shall be the least of:

1) The average suggested retail price derived from available medical supply
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catalogs and/or providers' price lists; or

2) The wholesale price derived from available medical supply catalogs and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

c) Medical supplies are medical items which are not durable or reusable such as surgical dressings, disposable syringes, catheters, urinary bags, etc. Payment for medical supplies is made for covered items at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate for each item of medical supplies shall be based on pricing for widely accepted quality items as defined in subsection (b) of this Section. The Department shall review and update the maximum allowable rate at least annually. The maximum allowable rate established for each item shall be the least of:

1) The average suggested retail price derived from available medical supply catalogs and/or providers' price lists; or

2) The wholesale price derived from available medical supply catalogs and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

d) Payment for Prosthetic and Orthotic Devices. Prosthetic and orthotic devices include corrective or supportive devices prescribed to artificially replace a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body. Payment for prosthetic and orthotic devices is made for covered items or services at the lesser of the provider's charge or the maximum allowable rate established by the Department. The maximum allowable rate for each item of prosthetic and orthotic devices shall be based on pricing for widely accepted quality items as defined in subsection (b) of this Section. The Department shall review and update the maximum allowable rate at least annually. The maximum allowable rate established for each item shall be the least of:

1) The average suggested retail price derived from available medical supply catalogs and/or providers' price lists; or
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2) The wholesale price derived from available medical supply catalogs and/or providers' price lists for each item plus 50 percent; or

3) The Medicare allowable rate for covered Medicare items or services.

e) Payment for hearing aids shall be made at the lesser of the provider's charge or the maximum allowable rate established by the Department. The hearing aid shall be priced by the Department at the vendor's actual acquisition cost, without exceeding the Department's upper limits of reimbursement for the item. Acquisition cost is defined as the actual amount the supplying provider pays for the hearing aid(s). Any discounts, rebates or bonuses shall be subtracted when calculating the acquisition cost. The amount of any rebates or bonuses shall be prorated on all purchases for which the rebate or bonus was earned. The prorated share shall be subtracted when calculating the acquisition cost of the item. Verification of the vendor's acquisition cost must be attached to the request for reimbursement. In addition to payment for the acquisition costs, the Department will pay a dispensing fee. Payment for a dispensing fee shall include reimbursement for fitting, follow-up visits, shipping and retail markup. The Department shall review and update the maximum allowable rate at least annually.

1) To establish the maximum limit for the acquisition cost of the hearing aid, the Department shall review wholesale prices from available supply catalogs and provider price lists for the most widely accepted brands and types of technology.

2) To establish the maximum allowable rate for the dispensing fee, the Department shall use an average of available rates charged by audiologists for three hearing aid follow-up visits, not to exceed the Department's maximum allowable rate for a physician visit of low complexity for an established patient, plus the average of available shipping fees charged by the wholesaler for hearing aid shipping and an amount for the retail markup, determined by taking 50 percent of the average wholesale price of the hearing aids reviewed.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.493 Payment for Helicopter Transportation

Notwithstanding the provisions set forth in this Section, beginning for the period of July 1, 2002, through June 30, 2003, the reimbursement rates paid for helicopter transportation services shall
be the lesser of the provider's usual and customary charge to the general public or 94 percent of
the fiscal year 2002 rate otherwise determined by the Department under this Section. Payment
for helicopter transportation services shall be made in accordance with the methodologies
outlined in this Section. In no case shall rates exceed the Medicare allowable, where applicable,
or the rates charged to the general public. The Department shall pay for medically necessary
helicopter transportation services provided in accordance with Section 140.491(b)(4) at an all
inclusive rate that includes base rate, mileage, supplies and all other services.

a) Helicopter transportation providers will be reimbursed a maximum rate per trip or
the usual and customary charges, whichever is less.

b) If a hospital provides the transport team but does not own the helicopter, the
Department will equally divide the established reimbursement rate or the usual
and customary charges of the provider, whichever is less, between the hospital
and the helicopter provider.

c) Hospitals that own their own helicopter and report its costs on their cost reports
will not be paid for helicopter transportation services.

d) The Department shall not cover the services of helicopter transportation providers
that have entered into payment agreements with receiving facilities.

e) Helicopter transportation claims that are denied because the patient does not meet
the medically necessary criteria (see Section 140.491(b)(1)), but does meet
emergency ground transportation criteria, will be reimbursed by the Department
at the appropriate ground rate.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

SUBPART E: GROUP CARE

Section 140.523 Bed Reserves

a) Nursing Facilities

1) All payable bed reserves must:

   A) be authorized by a physician;

   B) have post payment approval from Bureau of Long Term Care staff
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based on satisfying the requirements of this Section;

C) be limited to residents who desire to return to the same facility; and

D) be limited to facilities having a 93 percent or higher occupancy level. The occupancy level shall be calculated including both payable and non-payable (non-payable defined as those residents that have transitioned from the maximum days allowed for payable bed reserve to non-payable bed reserve status) bedhold days as occupied beds.

2) The Department shall not make payment for resident absences due to hospitalization. In accordance with the Nursing Home Care Act [210 ILCS 45/3-401.1], a recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following a hospital admission. Payment may be approved for hospitalization for a period not to exceed ten days per hospital stay. The day the resident is transferred to the hospital is the first day of the nonpayable reserve bed period.

3) Payment may be approved for home visits which have been indicated by a physician as therapeutically beneficial. In such instances, bed reserve is limited to seven consecutive days in a billing month or ten non-consecutive days in a billing month. The day after the resident leaves the facility for a therapeutic home visit is the first day of the payable or nonpayable reserve bed period. Home visits may be extended with the approval of the Department.

4) Bureau of Long Term Care staff will approve ongoing therapeutic home visits based on the physician's standing orders for the individual. Standing orders for therapeutic home visits limited to ten days per month are valid for a period not exceeding six months.

5) Payment for approved bed reserves is a daily rate at 75 percent of an individual's current Medicaid per diem.

6) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.
b) ICF/MR Facilities (including ICF/DD and SNF/Ped licenses)

1) All bed reserves must:
   A) be authorized by the interdisciplinary team (IDT); and
   B) be limited to residents who desire to return to the same facility.

2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments.

3) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

4) Payment may be approved for hospitalization for a period not to exceed 45 consecutive days. The day the resident is transferred to the hospital is the first day of the reserve bed period. Payment for approved bed reserves for hospitalization is a daily rate at:
   A) 100 percent of a facility's current Medicaid per diem for the first ten days of an admission to a hospital;
   B) 75 percent of a facility's current Medicaid per diem for days 11 through 30 of the admission;
   C) 50 percent of a facility's current Medicaid per diem for days 31 to 45 of the admission.

5) Payment may be approved for therapeutic visits which have been indicated by the IDT as therapeutically beneficial. There is no limitation on the bed reserve days for such approved therapeutic visits. The day after the resident leaves the facility is the first day of the bed reserve period. Payment for approved bed reserves for therapeutic visits is a daily rate at:
   A) 100 percent of a facility's current Medicaid per diem for a period not to exceed ten days per State fiscal year;
Section 140.551 General Service Costs Updates

a) General Service costs (mostly hotel costs – food, dietary, laundry, utilities, maintenance – see Section 140.531) shall will be updated by using nationally published indices specific to nursing home costs. (Health Care Cost Review, a publication of the Cost Information Forecasting Service, published quarterly by DRI-WEFA, Inc., a Global Insight Company, 24 Hartwell Avenue, Lexington, Massachusetts 02421 (2001). This incorporation by reference does not include any later amendments or editions.) A weighted average of the DRI index and the CPI for urban food and beverages and the DRI forecast for food and feed. These indexes will be weighted according to HCFA's SNF facility operating cost index. Utilities will be updated by the DRI Implicit Price Deflator Consumer Expenditures for fuel, oil, coal, electricity, natural gas, urban water, and sewage maintenance. Supplies will be updated by the Chase Implicit Price Deflator, Consumer Expenditures for household operations, services and other from the mid-point of the reporting period to the mid-point of the anticipated rate year. Dietary, housekeeping, and laundry costs (salaries, as supplies are adjusted out) will be updated by the DRI average hourly earnings, production workers for nursing and personal care facilities—North Central Region experienced and projected, adjusted to the Illinois experience as follows: 1) The rate of wage inflation for Illinois nursing homes from the calendar year 1977 through the most current reporting period will be determined for dietary, housekeeping, and laundry personnel by comparing the difference between the rate of wage inflation in 1977 and the rate in the cost reporting year. This rate of inflation, however, will be adjusted to exclude any changes caused by minimum wages over and above the underlying rate of inflation. The impact of the minimum wage will be calculated separately as specified in Section 140.555. 2) The rate of wage inflation as calculated in (a) (1) above will be compared to the experienced wage rate other increase for the same period. 3) The resultant factor will become an adjuster which is applied to DRI average hourly earnings, production workers for nursing and personal care facilities North Central Region projections from the year of the cost report to the rate year. b) Each of the components will be weighted for their contribution to total General Service Costs to form a General Services Inflation index. c) Projected producer price index, gas and electricity indexes, household operations Index and wage rate other will be based on generally accepted national economic forecasts, such as Chase Econometrics and DRI.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.553 General Administrative Costs Updates
General Administrative costs (see Section 140.533) shall be updated by using nationally published indices specific to nursing home costs. (Health Care Cost Review, a publication of the Cost Information Forecasting Service, published quarterly by DRI-WEFA, Inc., a Global Insight Company, 24 Hartwell Avenue, Lexington, Massachusetts 02421 (2001). This incorporation by reference does not include any later amendments or editions.) Prior to any updating, fringe benefits and payroll taxes will be prorated to General Service and Program areas on the basis of salaries paid in those areas. (The prorated amount will be updated at the same rate as the other portions of those cost centers.) General Administrative costs (see Section 140.533) will be updated by a weighted average of the general service inflator and the nursing and program inflator adjusted to Illinois nursing homes as follows: a) Prior to any updating, fringe benefits and payroll taxes will be prorated to General Service and Program areas on the basis of salaries paid in those areas. (The prorated amount will be updated at the same rate as the other portions of those cost centers.) b) An average rate of increase for the other two operating cost centers—General Services and Program costs—will be calculated. It will be a weighted average based on the relative contribution of each to average nursing home expenditures. c) The resulting factor will be used to update General Administrative costs.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.554 Component Inflation Index (Repealed)

The component inflation index will be re-evaluated at the mid-point of the rate year. If the total projected component inflation index differs from the actual total component inflation index by more than 5 percentage points, then rates will be adjusted prospectively to reflect the actual total component inflation index.

(Source: Repealed at 27 Ill. Reg. 18629, effective November 26, 2003)

Section 140.700 Discharge of Long Term Care Residents

a) A nursing facility participating in the Medical Assistance Program is prohibited from failing or refusing to retain as a resident any person because he or she is a recipient or an applicant for the Medical Assistance Program. A recipient or applicant shall be considered a resident in the nursing facility during any hospital stay totaling ten days or less following a hospital admission regardless of whether or not the nursing facility qualifies for payment for bed reserve per the criteria stated in Section 140.523.

b) If a nursing facility should refuse to accept a resident back in the facility after a
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stay in the hospital of less than ten days, the result may be that the resident will thereafter incur hospital bills of a greater amount than the nursing facility care would have cost. If the Department were to become liable to pay such hospital bills as a result of the nursing facility's refusal to take the recipient back into the facility, the Department shall recoup its costs for that unnecessary hospitalization from the nursing facility. The provider will be required to pay the Department the portion of the hospital bill that is in excess of the amount that would otherwise have been paid for care in the nursing facility from the date on which the nursing facility refused to accept the resident's return. The Department will notify the provider of its intent to recoup and opportunity for a hearing shall be given pursuant to 89 Ill. Adm. Code 104, Subpart C.

c) A nursing facility must establish and follow a written policy under which a resident, whose hospitalization exceeds ten days or therapeutic leave exceeds the bed reserve period specified in Section 140.523, is readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private, same sex room if the resident requires the services provided by the nursing facility and is eligible for Medicaid certified facility services.

d) The nursing facility must permit each resident to remain in the nursing facility and not transfer or discharge the resident except in specific instances as stated at 77 Ill. Adm. Code 300.3300(c)(1)(A) through (C).

e) For all Medicaid certified nursing facilities, notice of transfer or discharge must be made to any resident 30 days before the resident is transferred or discharged as mandated by 42 CFR 483.12 (a)(4)(B). In addition to requirements stated at 77 Ill. Adm. Code 300.3300(e), the contents of the notice shall also include requirements under 42 CFR 483.12(a)(5).

f) Pursuant to Section 1919(c)(2)(F) of the Social Security Act and Section 140.506 of this Part, a nursing facility that voluntarily withdraws from participation in the Medical Assistance Program, but continues to provide nursing facility services, is prohibited from using the facility's voluntary withdrawal from participation as an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal, including those residents who were not entitled to coverage under the Medical Assistance Program as of that day.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)
Section 140.830  Appeals of Rate Determinations

a) Except as indicated in subsection (b) of this Section, the Department shall notify all nursing facilities providers of their support and capital rates for the next year no later than 30 days before the beginning of the rate year, which, effective July 1, 1984, shall be the same as the State's fiscal year. Appeals of rate determinations shall be submitted in writing to the Department. Except as indicated in subsection (b) of this Section, all appeals received within 30 days after rate notification shall, if upheld, be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month following the date the complete appeal was received.

b) The Department shall notify all nursing facilities of their nursing rate no later than 30 days before the beginning of the rate quarter pursuant to 89 Ill. Adm. Code 147.150. Appeals shall be submitted to the Department no later than 30 days after the date of the Department's notice to the facility of the rate. The results of an appeal shall become effective the first day of the applicable quarter.

c) Appeals of rate determinations under this Section shall be submitted in writing to the Chief, Bureau of Long Term Care. The Department of Public Aid shall rule on all appeals within 120 days after the date of appeal, except that if the Department requires additional information from the facility the period shall be extended until such time as the information is provided. Except for the rate identified in subsection (b) of this Section, appeals for any rate year must be filed before the close of the rate year.

(Source: Amended at 27 Ill. Reg. 18629, effective November 26, 2003)

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 140.922(b)(3)(A) that meet the criteria specified in 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.
2) Participating FQHC's, as described in Section 140.922(b)(3)(B) and 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.

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(b)(3)(D) 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.

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 27 Ill. Reg. 18629, effective November 26, 2003)
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1) **Heading of the Part:** Specialized Health Care Delivery Systems

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

3) **Section Numbers:**
   - 146.225 Amendment
   - 146.255 Amendment

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

5) **Effective Date of Amendments:** November 26, 2003

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

7) **Do these amendments contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 18, 2003 (27 Ill. Reg. 10638)

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

11) **Differences Between Proposal and Final Version:** No changes have been made to the proposed rulemaking.

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 these amendments replace emergency amendments currently in effect?** Yes

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

15) **Summary and Purpose of Amendments:** These amendments pertaining to Supportive Living Facilities (SLFs) provide for the elimination of bed reserve payments from the Department to hold a long term care bed during a resident's temporary absence. Related changes are also being made regarding the discharge of residents from SLFs.

16) **Information and questions regarding these adopted amendments shall be directed to:**
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

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

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

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

PART 146
SPECIALIZED HEALTH CARE DELIVERY SYSTEMS

SUBPART A: AMBULATORY SURGICAL TREATMENT CENTERS

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SUBPART B: SUPPORTIVE LIVING FACILITIES

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146.265 Records Requirements
146.270 Quality Assurance Plan
146.275 Monitoring
146.280 Termination or Suspension of SLF Provider Agreement
146.285 Voluntary Surrender of Certification
146.290 Geographic Groups


SUBPART B: SUPPORTIVE LIVING FACILITIES

Section 146.225 Reimbursement for Medicaid Residents

SLFs shall accept the reimbursement provided in this Section as payment in full for all services provided to Medicaid residents.

a) The Department shall establish its portion of the reimbursement for Medicaid residents by calculating 60 percent of the weighted average (weighted by Medicaid patient days) nursing facility rates for the geographic grouping as defined in Section 146.290. Each SLF shall be paid 60 percent of the weighted average nursing facility geographic group rate, based upon the nursing facility geographic group in which it is located. The rates paid to SLFs shall be reviewed annually, and adjusted, if necessary, on October 1 to assure that the rates coincide with 60 percent of weighted average nursing facility geographic group rates. Effective October 1, 2002, SLF rates shall remain at a minimum of the rate in effect as of September 30, 2002.
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b) The payment rate received by the SLF from the Department for services, with the exception of meals, provided in accordance with Section 146.230 shall constitute the full and complete charge for services rendered. Additional payment, other than patient credits authorized by the Department, may not be accepted. Meals are included in the room and board amount paid by the resident.

c) Single Occupancy: Each Medicaid resident of an SLF shall be allotted $90 per month as a deduction from his or her income as a protected amount for personal use. The SLF may charge each Medicaid resident no more than the current SSI rate for a single individual less $90 for room and board charges. Any income remaining after deduction of the protected $90 and room and board charges shall be applied first towards medical expenses not covered under the Department's Medical Assistance Program. Any income remaining after that shall be applied to the charges for SLF services paid by the Department.

d) Double Occupancy: In the event a Medicaid eligible resident chooses to share an apartment, the Medicaid resident of an SLF shall be allotted $90 per month as a deduction from his or her income as a protected amount for personal use. The SLF may charge each Medicaid resident no more than the resident's share of the current SSI rate for a couple less $90 for room and board charges. The room and board rate for two Medicaid eligible individuals sharing an apartment cannot exceed the SSI rate for a married couple even if the two individuals sharing an apartment are unrelated. Any income of an individual remaining after deduction of the protected $90 and room and board charges shall be applied first towards that individual's medical expenses not covered under the Department's Medical Assistance Program. Any income of an individual remaining after that shall be applied to that individual's charges for SLF services paid by the Department. If one, or both, of the individuals sharing an apartment is not Medicaid eligible, the SLF may negotiate its own rate with the non-Medicaid individual or individuals.

e) The room and board charge for Medicaid residents shall only be increased when the SSI amount is increased. Any room and board charge increase shall not exceed the amount of the SSI increase.

f) The Department shall not reimburse an SLF for services while a resident is temporarily absent from an SLF. An SLF continues to be responsible for notifying the Department of a resident's temporary absence from the SLF. The resident remains responsible for room and board charges during any temporary absence. Payment shall be made by the Department for up to 30 days per State fiscal year during a Medicaid resident's temporary absence from the SLF when
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the absence is due to situations including but not limited to hospitalization or vacation. The resident shall continue to be responsible for room and board charges during any absence. Refer to Section 146.255(b) and (d)(7) for involuntary discharge criteria relating to temporary absence. Nursing facilities that have a distinct part certified as an SLF shall not consider converted beds in the nursing facility's licensed capacity when calculating the 93 percent occupancy level for bed reserve payment pursuant to 89 Ill. Adm. Code 140.523.

(Source: Amended at 27 Ill. Reg. 18671, effective November 26, 2003)

Section 146.255 Discharge Criteria

a) If a resident does not meet the terms for occupancy as stated in the resident contract, the SLF discharge proceedings shall not commence involuntary discharge until the SLF has discussed the reasons for involuntary discharge there has been discussion with the resident and his or her designated representative concerning the reason for involuntary discharge. Documentation of the discussion shall be placed in the resident's record.

b) The SLF shall provide a resident with a 30-day written notice of proposed involuntary discharge unless such a delay might jeopardize the health, safety, and well-being of the resident or others. A copy of the notice required by this subsection (b) shall be placed in the resident's record and a copy shall be transmitted to the resident and the resident's designated representative. The notice shall be on a form prescribed by the Department and shall contain all of the following: An SLF may provide the 30 day written notice on the first day of an unpaid temporary absence or at any point during the unpaid temporary absence.

1) The stated reason for the proposed discharge;

2) The effective date of the proposed discharge;

3) A statement in not less than 14-point type that reads: "You have a right to appeal the SLF's decision to discharge you. You may file a request for a hearing with the Department within ten days after receiving this notice. If you request a hearing, you will not be discharged during that time unless you are unsafe to yourself or others. If the decision following the hearing is not in your favor, you will not be discharged prior to the tenth day after receipt of the Department's hearing decision unless you are unsafe to yourself or others. A form to appeal the SLF's decision and to request a
DEPARTMENT OF PUBLIC AID

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hearing is attached. If you have any questions, call the Department at the telephone number listed below.

4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and

5) The name, address, and telephone number of the person charged with the responsibility of supervising the discharge.

c) The SLF shall prepare plans to ensure safe and orderly involuntary discharge and protect resident health, safety, welfare and rights.

d) A resident may be involuntarily discharged only if one or more of the following occurs:

1) He or she poses an immediate threat to self or others.

2) He or she needs mental health services to prevent harm to self or others.

3) He or she has breached the conditions of the resident contract.

4) The SLF has had its certification terminated, suspended, not renewed, or has voluntarily surrendered its certification.

5) The SLF cannot meet the resident's needs with available support services.

6) The resident has received proper notice of failure to pay from the SLF. The resident shall have the right to make payment up to the date that the discharge is to be made and then shall have the right to remain in the SLF. This subsection (d)(6) does not apply to Medicaid residents when the failure to pay relates to the Medicaid payment.

7) The resident exceeds the SLF's policy for what constitutes a temporary absence from the SLF. A temporary absence shall not be considered a basis for an involuntary discharge of a Medicaid resident until the Department has stopped payment pursuant to Section 146.225(f).

e) The notice required under subsection (b) of this Section shall not apply in any of the following instances:
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1) When an emergency discharge is mandated by the resident's health care or mental health needs and is in accord with the written orders and medical justification of the attending physician.

2) When the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record.

f) The notice required in subsection (b) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed discharge; 2) The effective date of the proposed discharge; 3) A statement in not less than 14-point type, which reads: "You have a right to appeal the SLF's decision to discharge you. You may file a request for a hearing with the Department within ten days after receiving this notice. If you request a hearing, you will not be discharged during that time unless you are unsafe to yourself or others. If the decision following the hearing is not in your favor, you will not be discharged prior to the tenth day after receipt of the Department's hearing decision unless you are unsafe to yourself or others. A form to appeal the SLF's decision and to request a hearing is attached. If you have any questions, call the Department at the telephone number listed below."; 4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and 5) The name, address, and telephone number of the person charged with the responsibility of supervising the discharge.

If the resident submits a request for hearing made under subsection (b) of this Section, the involuntary discharge shall be stayed pending a hearing or appeal of the decision, unless a condition which would have allowed discharge in less than 30 days as described under subsections (e)(1) and (2) of this Section develops in the interim.

A copy of the notice required by subsection (b) of this Section shall be placed in the resident's record and a copy shall be transmitted to the resident and the resident's designated representative.

When nonpayment is the basis for involuntary discharge, the resident shall have the right to redeem up to the date that the discharge is to be made and then shall have the right to remain in the SLF.

In determining whether an involuntary discharge is justified, the burden of proof in the hearing rests with the entity requesting the discharge.

If the Department determines that an involuntary discharge is justified under subsection (d) of this Section, the resident shall not be required to leave the SLF before the tenth day after receipt of the Department's hearing decision unless a
condition which would have allowed discharge as described under subsections (e)(1) and (2) of this Section develops in the interim.

\[\text{i) The SLF shall offer relocation assistance to residents involuntarily discharged under this Section, including information on available alternative placements. A resident or his or her designated representative shall be involved in planning the discharge and shall choose among the available alternative placements. Where an emergency makes prior resident involvement impossible, the SLF may arrange for a temporary placement until a final placement can be arranged. The SLF may offer assistance in relocating from a temporary to a final placement.}\]

\[\text{j) When a resident discharges on a voluntary basis, he or she shall provide the SLF with 30 days written notice of intent to discharge, except where a delay would jeopardize the health, safety, and well-being of the resident or others.}\]

\[\text{n) In cases of discharge under subsection (d), (e), (m) or (o) of this Section, the resident is no longer bound by the resident contract.}\]

\[\text{k) The Department may discharge any resident from an SLF when any of the following conditions exist:}\]

1) The Department has terminated or suspended the SLF certification.

2) The SLF is closing or surrendering its certification and arrangement for relocation of the resident has not been made at least 30 days prior to closure or surrender.

3) The Department determines that an emergency exists which requires immediate discharge of the resident.

\[\text{l) In cases of discharge under subsection (d) or (k) of this Section, the resident is no longer bound by the resident contract. In the event of a Department-initiated discharge, the Department may offer relocation assistance to residents. A resident or his or her designated representative shall be involved in planning the discharge and shall choose among the available alternative placements.}\]

(Source: Amended at 27 Ill. Reg. 18671, effective November 26, 2003)
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NOTICE OF ADOPTED AMENDMENTS

1) **Heading of the Part:** Reimbursement for Nursing Costs for Geriatric Facilities

2) **Code Citation:** 89 Ill. Adm. Code 147

3) **Section Numbers:**

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4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 92-848

5) **Effective Date of Amendments:** November 26, 2003

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

7) **Do these amendments contain incorporations by reference?** Yes
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8) A copy of the adopted amendments, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.


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

11) Differences Between Proposal and Final Version:

Section 147.125

In subsection (a), incorporation by reference information has been added which reads, "(Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002). This incorporation by reference includes no later amendments or editions.)"

Subsections (b)(1) and (2) have been revised to read:

b) 1) Complete a full Minimum Data Set (MDS) for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Sections T and U. RAPs and Sections T and U shall only be completed at admission, annually, for a significant change or for a significant correction of a prior MDS.

2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment. The rate set will be based on the MDS received two quarters prior to the rate effective date and MDS' not received within 31 days will be given a default rate.

Section 147.150

The second sentence of subsection (a) has been revised to read, "Reimbursement for this component shall be calculated using the Minimum Data Set (MDS)."

The first sentence of subsection (b) has been revised to read, “The nursing component of the rate shall be calculated annually and may be adjusted quarterly.”
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The beginning of the second sentence of subsection (b) has been changed to read, “The determination of rates shall be based upon...”.

The second sentence of subsection (b) has been further revised by adding "as of 30 days prior to the rate period" after "Management Information System".

A new sentence has been added at the end of subsection (b) which reads, “The nursing component of the rate may be adjusted on a quarterly basis if any of the following conditions are met:”

The following subsections have been added to subsection (b):

b)  1) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds total variable nursing time calculated for the previous rate quarter by more than five percent.

2) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds:
   A) total variable nursing time as calculated for the annual rate period by more than ten percent;
   B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

3) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No quarterly nursing component rate reduction shall exceed five percent from the previous rate quarter.

In subsection (c)(1)(A), "geographical location" has been changed to "regional rate area".

In subsection (c)(1)(B), “base wage” has been changed to “mean wage”.

In subsection (c)(1)(D), the cross-reference has been changed to "(c)(1)(A)"
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Subsection (c)(1)(E) has been revised to read, “On July 1 of each year beginning July 1, 2003, the base wage calculated in subsection (c)(1)(C) of this Section shall be multiplied by a ratio:”.

In subsection (e)(4), the cross reference "(c)(1)(D)" has been changed to "(c)(1)(E)".

Section 147.175

Subsection (a) has been revised by deleting the comma, adding "or" after "electronically", and by deleting ", or at some other location".

Subsections (d) and (e)(2)(B) have each been revised by deleting both occurrences of "verification".

Subsections (d)(3), (e) and (e)(2) have been revised by deleting "verification".

Subsection (e)(2)(A)(i) has been revised to read, "Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.”

The first sentence in subsection (e)(2)(A)(iii) has been revised to read, “Decrease the rate by more than ten percent...”. And in the last sentence of this subsection, “two percent” has been changed to “ten percent”.

In subsection (e)(2)(B), both occurrences of “15 minutes” have been changed to “25 percent”.

TABLE A

The proposed text at Section 147.TABLE A was revised throughout to enhance the usability of the TABLE. The revised text of TABLE A was included in the Second Notice of Proposed Rulemaking. In some instances, use of the symbols for "less than or equal to" and "more than or equal to" were clarified.

No other substantive changes have been made in the proposed rulemaking.

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 these amendments replace emergency amendments currently in effect? Yes
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14) Are there any other amendments pending on this Part? No

15) Summary and Purpose of Amendments: Pursuant to Public Act 92-848, the Department is establishing a new methodology for the nursing component of rates for Medicaid funded nursing facilities (NF). Skilled nursing facilities and intermediate care facilities that are licensed under the Nursing Home Care Act and certified under the Medicaid Program will be affected by the new payment provisions. For the nursing component, the Department will use the Minimum Data Set (MDS), a federally required assessment form, to collect information from nursing facilities concerning the condition of NF residents and establish a rate based on all Medicaid residents in the NF. The nursing component will be calculated and adjusted on a quarterly basis.

Under the Act, the Department has developed the new rate methodology for which new payments are subject to appropriation levels provided by the General Assembly. Any increases will be effective only if specific appropriation is made for this purpose. A transition period of two years, beginning July 1, 2003, is provided for initial implementation of the new payment methodology. During this period, for an NF that would receive a lower nursing component rate under the new system than under the current system, the nursing component rate will be held at the current rate until a higher rate is achieved by that NF. Because of the MDS based rate system, the Department's rules relating to Inspection of Care for NFs are being repealed or amended.

If there is no specific appropriation for this purpose, there is no annual budgetary impact resulting from these proposed rate changes. Public Act 92-848 states that rates under the new methodology shall be adjusted subject to appropriations provided by the General Assembly. If and when monies are made available, they will be distributed as allocated in these rules: first to restore the 5.9% reduction from FY 2003, then to distribute monies according to the new methodology. Nothing in these rules should be construed as suggesting that new monies are currently available or will be made available at any point in the future.

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

Joanne Scattoloni
Office of the General Counsel, Rules Section
Illinois Department of Public Aid
201 South Grand Avenue East, Third Floor
Springfield, Illinois 62763-0002
(217) 524-0081
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The full text of the adopted amendments begins on the next page:

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

PART 147
REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section
147.5 Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Repealed)
147.15 Comprehensive Resident Assessment (Repealed)
147.25 Functional Needs and Restorative Care (Repealed)
147.50 Service Needs (Repealed)
147.75 Definitions (Repealed)
147.100 Reconsiderations (Repealed)
147.105 Midnight Census Report
147.125 Nursing Facility Resident Assessment Instrument Times and Staff Levels
147.150 Minimum Data Set (MDS) Based Reimbursement System Statewide Rates
147.175 Minimum Data Set (MDS) Integrity Referrals
147.200 Basic Rehabilitation Aide Training Program (Repealed)
147.205 Nursing Rates (Repealed)
147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)
147.300 Payment to Nursing Facilities Serving Persons with Mental Illness
147.301 Sanctions for Noncompliance
147.305 Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)
147.310 Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)
147.315 Comprehensive Functional Assessments and Reassessments (Repealed)
147.320 Interdisciplinary Team (IDT) (Repealed)
147.325 Comprehensive Program Plan (CPP) (Repealed)
147.330 Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)
147.335 Specialized Care – Behavioral Emergencies (Repealed)
147.340 Discharge Planning (Repealed)
147.345 Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)
147.350 Reimbursement for Additional Program Costs Associated with Providing
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Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities

147.TABLE A  Staff Time (in Minutes) and Allocation by Need Level
147.TABLE B  Staff Time and Allocation for Restorative Programs (Repealed)
147.TABLE C  Comprehensive Resident Assessment (Repealed)
147.TABLE D  Functional Needs and Restorative Care (Repealed)
147.TABLE E  Service (Repealed)
147.TABLE F  Social Services (Repealed)
147.TABLE G  Therapy Services (Repealed)
147.TABLE H  Determinations (Repealed)
147.TABLE I  Activities (Repealed)
147.TABLE J  Signatures (Repealed)
147.TABLE K  Rehabilitation Services (Repealed)
147.TABLE L  Personal Information (Repealed)


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Section 147.5 Reimbursement For Nursing Costs For Geriatric Residents In Group Care Facilities (Repealed)

a) Sections 147.15 through 147.175 describe the Department’s method of reimbursement for nursing costs for geriatric residents in group care facilities based on resident’s need for care and the time and type of staff required to provide that care.

b) Resident Assessment Guidelines

The Resident Assessment Instrument is used to assess the variable needs of public assistance residents for determination of statewide rates and facility reimbursement levels. The Resident Assessment guidelines are described in Sections 147.15 through 147.75.

c) Interpretive Guidelines

The interpretive guidelines have been developed as a reference and working tool for staff and nursing facilities during the Inspection of Care (IOC) survey. The interpretive guidelines are described in Section 147.Table C through Table L.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.15 Comprehensive Resident Assessment (Repealed)

a) Base Rate Services

One comprehensive resident assessment followed by quarterly reviews has been completed within the past year.

b) Type Code: Frequency Codes

1) Two or more full comprehensive assessments were necessary and completed in the past year (based upon admission date or completion date of the last full comprehensive assessment). The interdisciplinary team must examine each resident no less than once every 3 months and, as appropriate, revise the resident’s assessment to assure the continued accuracy of the assessment.

2) Nursing home residents admitted prior to October 1, 1990 are required to have a minimum data set comprehensive assessment completed before
Section 147.25 Functional Needs and Restorative Care (Repealed)

A Resident Assessment Instrument is used to assess the variable needs of public assistance residents for determination of statewide nursing rates and facility reimbursement levels. The Resident Assessment guidelines as described in this Section identify the functional needs of the resident and the programs developed to improve their functional abilities.

a) Category 1—Bathing/Grooming

1) Base Rate Services
   A) General reminders of when to take a bath;
   B) Assistance with combing/brushing hair or assistance with washing back; and
   C) One-to-one verbal instruction.

2) Functional
   A) Resident needs and receives hands-on assistance due to functional deficit(s) (as determined by physical or psychological causes). Resident is helped with bathing some part of his/her body. This includes oral hygiene, washing hair and shaving.
   B) Totally dependent. Resident requires and receives total assistance due to a functional deficit(s) (as determined by physical or psychological causes) from staff with bathing. Resident is bathed by a staff person whether the bath is given in the tub, shower, or bed.

3) Restorative
   Staff has developed and is implementing a specific program to assist resident to improve functional abilities in bathing and grooming due to a functional deficit(s) (as determined by physical or psychological causes).

4) Maintenance
   Restorative care and program continue to be implemented, and is at a maintenance level after initial improvement. Restorative care and program intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

5) An assessment shall be completed identifying the resident's current level of functioning in bathing and grooming. The assessment shall state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that
anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

b) Category 2—Clothing

1) Base Rate Services
   A) Assistance in choosing appropriate clothing; and
   B) Verbal reminders to dress.

2) Functional
   A) Resident needs and receives hands-on assistance due to a functional deficit(s) (as determined by physical or psychological causes). Resident requires and receives help with getting dressed. This involves the actual assisting with putting on clothes.
   B) Totally dependent. Resident requires and receives total assistance due to a functional deficit(s) (as determined by physical or psychological causes) from staff with dressing. Resident is dressed by a staff person and does not participate in dressing of self. This includes bedfast residents being dressed in gown, pajamas, etc.

3) Restorative
   Staff has developed and is implementing a specific program to assist resident to improve functional abilities in dressing due to a functional deficit(s) (as determined by physical or psychological causes).

4) Maintenance
   Restorative care and program continue to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident’s improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

5) An assessment shall be completed identifying the resident’s current level of functioning in dressing. The assessment shall state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

e) Category 3—Eating

1) Base Rate Services
   A) Routine tray preparation:
      i) opening milk cartons
      ii) cutting food
      iii) pouring coffee/beverages
      iv) buttering bread
   B) Verbal reminders to eat (encouragement)
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2) Functional
   A) Resident needs and receives hands-on staff assistance to eat some part of the meal due to a functional deficit(s) (as determined by physical or psychological causes).
   B) Totally dependent. Resident requires and receives total assistance from staff with eating due to a functional deficit(s) (as determined by physical or psychological causes).
   C) Tube Feeding. Resident requires and receives tube feeding. Resident is fed through naso-gastric tube or gastrostomy tube regardless of other oral food intake.

3) Restorative
   Staff has developed and is implementing a specific program to assist resident to improve functional abilities in eating due to a functional deficit(s) (as determined by physical or psychological causes).

4) Maintenance
   Restorative care and program continues to be implemented, and is at a maintenance level after initial improvement. Restorative care and intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

5) An assessment shall be completed identifying the resident's current level of functioning in eating. The assessment shall state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

d) Category 4—Mobility

1) Base Rate Services
   A) Repositioning for comfort;
   B) Supervision of ambulatory residents;
   C) Redirection of lost and/or wandering residents;
   D) Reminders to use handrails;
   E) Reminders to use assistive devices correctly;
   F) Residents who are totally bedfast; and
   G) Assistance in and out of bathtub or shower.

2) Functional
   A) Resident needs and receives hands-on assistance with standing and transfer or movement about the facility due to a functional deficit(s) (as determined by physical or psychological causes). Resident can ambulate or move about facility per self once transfer
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is completed. Or, resident can transfer independently, but staff
must assist resident with movement about the facility.

B) Resident requires and receives hands-on assistance with transfer
from bed to chair or wheelchair and requires and receives
assistance with movement about the facility due to a functional
deficit(s) (as determined by physical or psychological causes).

3) Restorative
Staff has developed and is implementing a specific program to assist
resident to improve functional abilities in transferring, ambulation,
wheelchair mobility, and/or bed mobility due to a functional deficit(s) (as
determined by physical or psychological causes).

4) Maintenance
Restorative care and program continues to be implemented, and is at a
maintenance level after initial improvement. Restorative care and
intervention have been modified and continue to be implemented to
maintain the resident's improved condition. When scoring this Level 2
Maintenance, the ADL component must be scored zero.

5) An assessment shall be completed identifying the resident's current level
of functioning in bed mobility, transfer and locomotion. The assessment
shall state what the resident is able to do independently and what
assistance is required and what makes it necessary. A definite base must
be established so that anyone reading the assessment and progress notes
can tell whether the individual has progressed in ability or has lost
functional ability.

e) Category 5—Continence
1) Base Rate Services
Stand-by assistance provided, including assisting with clothing, verbal
cues, etc.

2) Functional
A) Resident is incontinent of bladder and/or bowel (includes
dribbling).
B) Resident is assisted to toilet as frequently as indicated by resident
need.

3) Restorative Care
Staff has assessed, planned, implemented and monitored, according to
individual need, a specific formalized program to assist resident to
improve abilities in continence.

4) Maintenance
Restorative care and formalized program continues to be implemented and
is at a maintenance level after initial improvement. Restorative care and
intervention have been modified and continue to be implemented to maintain the resident's improved condition. When scoring this Level 2 Maintenance, the ADL component must be scored zero.

5) An assessment shall be completed identifying the resident's current level of functioning in continence. The assessment shall state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability, or has lost functional ability.

6) Prior to a resident being given credit for restorative care in any program, the following must be met:
   A) An assessment completed by a registered nurse, identifying the resident's current level of functioning, the cause or contributing factors of current incontinence, and a plan developed to increase this level of functioning by the interdisciplinary team.
   B) A reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response.
   C) Staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly.
   D) The program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his/her functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

f) Category 6—Psychosocial/Mental Status
   1) Base Rate Services
      B) Additional reminders for bathing, clothing, grooming and taking medicine;
      C) Explanations and assurances;
      D) Intervention/interaction with family; and
      E) Reminders to attend activities;
   2) Functional
      Staff has developed and is implementing a specific intervention program that addresses psychosocial needs. This program is monitored by a Qualified Health Professional "QHP" as evidenced by signing off on assessment and response notes, with written recommendations as appropriate in the clinical record. This program must be in the care plan and the resident's response to staff's intervention must be recorded in the clinical record at least monthly. Interventions may occur in 1:1 scheduled
counseling sessions, group sessions no larger than eight, or strictly incident intervention. Incident intervention only programs are limited to residents with severe behavior problems which preclude participation in a more structured setting. Incident intervention only must consist of a plan with staff using ongoing specifically identified interventions for identified behavior occurrences. The plan may consist of any combination of the above-mentioned techniques. Interventions must take place at least three times a week.

g) Category 7—Communication

1) Functional Description
   Resident has been assessed, needs and receives special assistance or care as a result of altered sensory reception or transmission including visual, auditory, or speech.

2) Type Code: Frequency Codes
   A) Interventions are developed and implemented to address one communication deficit.
   B) Interventions are developed and implemented to address two communication deficits.
   C) Interventions are developed and implemented to address three communication deficits.

3) Speech Therapy
   A) General Criteria
      There must be a reasonable likelihood that the treatment will improve the resident's functional means of communication. While there is no specific time limit on the duration of these services, improvement of the resident's condition must be evident in the therapist's documentation.
   B) Specific Criteria
      Resident requires and facility provides a Speech-Language Pathology and Audiology (SLP/A) Rehabilitative Program as ordered by a physician, planned and designed specifically for the resident by a certified speech language pathologist/audiologist or Clinical Fellow (CFY) and including measurable goals. This program is carried out on a regularly scheduled basis by a certified speech-language pathologist/audiologist or Clinical Fellow (CFY). Progress notes are to be recorded as to the improvement of the resident's condition. This service must be reevaluated monthly by the certified speech-language pathologist/audiologist.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)
Section 147.50 Service Needs (Repealed)

This Section describes the Department’s method of reimbursement for nursing costs for service needs through the use of the Resident Assessment Instrument. It further describes therapy services that may be needed by residents that are reimbursable through a separate post-payment audit system.

a) Category I—Appliances
   1) Type Code: Frequency codes
      One or more appliances.
   2) Appliances.
      Appliances, restricted to the following devices, that the facility staff assist
      the resident with applying, and/or maintenance/care of the appliance as
      indicated per physician's or dentist's orders and/or resident plan of care.
      A) Hearing device (one or two)
      B) Elastic-joint supports
      C) Ted or jobst hose (one or two)
      D) A neck brace
      E) A back brace
      F) Artificial-limbs
      G) Trusses (male and female)
      H) Prescribed ACE bandages
      I) Cervical collars
      J) Leg braces
      K) Arm braces
      L) Head braces
      M) Splints
      N) Slings
      O) Contact lens
      P) Artificial eye
      Q) Protective helmet
      R) Cylinder braces
      S) Eyeglasses
      T) Dentures
      U) Electrolarynx
      V) Augmentative communication devices
      W) TENS Unit
      X) Wheelchair-cuffs
      Y) ADL-adaptive equipment
      Z) Abductor-bar/pillow
AA) Self-release safety devices

b) Category 2—Catheterization
Type code: Intensity codes
Indwelling, Texas, supra pubic catheter, intermittent catheterization, including care and irrigation.

c) Category 3—Pressure Ulcer Treatment
Type code: Intensity codes
1) Resident has been admitted with a stage I or II pressure ulcer.
2) Resident has been admitted with a stage III or IV pressure ulcer.
3) Resident has a Stage I or II pressure ulcer that developed while in the facility.
4) Resident has a Stage III or IV pressure ulcer that developed while in the facility.

d) Category 4—Pressure Ulcer Prevention
Type Code: Intensity Codes
1) Resident has been assessed, using an assessment instrument, to determine risk for developing pressure ulcers and has scored in the moderate risk category. A comprehensive preventative program as specified in the care plan is implemented and must address, but is not limited to, positioning schedules, range of motion program, nutritional support, and skin measures (i.e., whirlpool, etc.) as determined by facility policy.
2) Resident has been assessed, using an assessment instrument, to determine risk for developing pressure ulcers and has scored in the high risk category. A comprehensive preventative program as specified in the resident care plan is implemented and must address, but is not limited to, special mattresses or wheelchair cushions to reduce pressure, a positioning schedule, range of motion program, nutritional support and daily skin checks, and skin care measures (i.e., whirlpool, etc.) as dictated by a facility policy for high risk residents.

e) Category 5—Wound Care
Type code: Intensity codes
1) Dressings and/or skin treatments for noninfected areas.
2) Complex dressings (such as sterile dressings or post-op) and/or treatment to lesions that are infected.

f) Category 6—Injections
Type code: Frequency codes
1) Requires and receives injections less than daily but at least once a month, on a regular basis as per physician order.
2) Requires and receives one or more injections daily.

g) Category 7—Intravenous Therapy: I.V.’s and Clysis
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Type code: Frequency codes
1) Required and received I.V. or clysis for at least 48 hours (intermittent or continuous) during the past six months.
2) Required and received I.V. or clysis seven or more days in past six months.

h) Category 8—Laboratory Specimen Service
Type code: Frequency codes
Resident required and facility staff collected one or more of the following: a specimen including blood specimen, urine specimen either by midstream "cleancatch" or by catheter, sputum specimen, stool specimen, swabs of throat, lesions, diabetic urine test, telephonic pacemaker check or electrocardiogram or oximeter or glucometer readings or checking and monitoring of shunts. Specimens collected by an outside lab are not included.
1) One time in the last six months.
2) Once a week.
3) Daily.

i) Category 9—Medications/Medication Monitoring
1) Base Rate Services
   A) Routine med passes;
   B) Routine observation for medication side effects;
   C) Encouraging residents to take medications;
   D) PRN medication;
   E) Special monitoring done by licensed or unlicensed personnel with licensed supervision, including vital signs, lab work and clinitests that result in few, if any, changes in dosage or medication or amount of assessment necessary.

2) Type code: Intensity codes
Resident needs and receives medication four times a day or more during off-hours or by multiple routes, and requires routine monitoring to check for untoward reaction or side effects. Also included is a resident who needs and receives medication that requires special monitoring by licensed personnel with need for assessing and reporting to physician if necessary, changes in resident status, lab work, side effects, or apparent drug interactions. This can result in an adjustment of dosage or medication, or in continuing assessment of an unstable condition.

3) Medication Programs
   A) Resident is on a supervised program to increase or maintain an acquired level of independent self-administration of medication. The resident's cognitive, physical and visual ability to carry out this responsibility has been assessed by the interdisciplinary team.
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Nursing staff is responsible for drug storage and for recording self-administration in the resident's medication administration record; or

B) Resident is involved in a program to discontinue or reduce psychotropic medication to the lowest possible dose necessary to control symptoms.

j) Category 10—Occupational Therapy and Related Rehabilitation Services

1) Type code: Intensity Code
A) The occupational rehabilitation program shall be ordered by a physician. It shall be planned and designed specifically for the resident by an occupational therapist registered/licensed (OTR/L) (68 Ill. Adm. Code 1315). The occupational rehabilitation services program shall be administered by a rehabilitation aide under the supervision of the OTR/L. There shall be a monthly review of progress documented by the OTR/L, or if written by the rehabilitation aide, co-signed by the OTR/L.
B) There must be a reasonable likelihood that the rehabilitation services will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan meeting review by the interdisciplinary team.

2) Occupational Therapy
A) The occupational therapy program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the OTR/L. The direct occupational therapy services shall be administered by a certified occupational therapy assistant/licensed (COTA/L) under the supervision of the OTR/L. There shall be a review of the progress documented either by the OTR/L or COTA/L monthly. The OTR/L must cosign the COTA/L's documentation monthly.
B) The occupational therapy shall be ordered by a physician. It shall be planned and designed specifically for the resident by an OTR/L. This plan must include measurable goals. The program shall be carried out on a regularly scheduled basis by an individual with qualifications of an OTR/L. There must be a review or progress towards goals documented by the OTR/L every month.
C) There must be a reasonable likelihood that the occupational therapy will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to
the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan review by the interdisciplinary team.

k) Category 11 – Physical Therapy and Related Rehabilitation Services

1) Type code: Intensity Code
   A) The physical rehabilitation program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the physical therapist (PT). The physical rehabilitation services shall be administered by a rehabilitation aide under the supervision of the PT. There shall be a monthly review of the progress documented by the PT or if written by the rehabilitation aide, co-signed by the PT.
   B) There must be a reasonable likelihood that the rehabilitation services will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan meeting review by the interdisciplinary team.

2) Physical Therapy
   A) The physical therapy program shall be ordered by a physician. It shall be designed and planned specifically for the resident by the PT. The direct physical therapy services shall be administered by a physical therapists assistant (PTA) under the supervision of the PT. There shall be a review of the progress documented either by the PT or the PTA monthly. The PT must cosign the PTA's documentation monthly.
   B) Physical therapy shall be planned and designed specifically for the resident by a PT. This plan must include measurable goals. The program shall be carried out on a regularly scheduled basis by an individual with qualifications of a PT. There must be a review of progress toward goals documented by the PT monthly.
   C) There must be a reasonable likelihood that the physical therapy will improve the resident's functional ability. While there is no specific time limit on the duration of these services, benefit to the resident's functional ability must be evident in the therapist's documentation. This service must be reviewed at the time of the care plan review by the interdisciplinary team.

l) Category 12 – Passive Range of Motion (PROM)
   Type code: Frequency Code
   Resident requires and receives PROM exercises to at least one extremity at least
m) Category 13—Ostomy Care
Type code: Intensity codes
Includes gastrostomy, ileostomy, jejunostomy and colostomy.
1) Uncomplicated care of ostomy (gastrostomy included). Includes routine care and maintenance of the ostomy, i.e., cleansing and appliance change.
2) Complex ostomy includes post/op operative, ostomies, care of Percutaneous Endoscopic Gastrostomy (PEG) tubes, or an ostomy that, given the patient’s overall condition, requires licensed care. All ostomies that have become excoriated or require a prescription medication application are included.

n) Category 14—Respiratory Therapy
1) Type code: Intensity codes
   A) Uncomplicated provision of these therapies. Resident is capable of administering his/her own respiratory therapy (oxygen and humidity) with minimum assistance from licensed personnel and routine monitoring by staff.
   B) Complex due to the nature of the resident’s condition, type procedure or multiplicity of procedures required. Positive pressure breathing therapy, aerosol therapy, etc. and complicated problems with oxygen-humidity is required by resident. Resident is totally dependent upon administration by licensed staff.
2) Respiratory therapy includes oxygen, positive pressure breathing therapy, humidity therapy, or aerosol therapy, postural drainage, percussion or vibration. Room humidifiers are not included.

o) Category 15—Suctioning
Type code: Frequency codes
1) Daily.
2) Twice or more daily.

p) Category 16—Tracheostomy Care
1) Type code: Intensity codes.
   A) Requires routine cleansing of tracheostomy site and non-sterile dressing change. Tracheostomy care managed by staff (see Category 15—Suctioning).
   B) Requires and receives complex care to tracheostomy site more than one time daily which includes the changing of sterile or complex dressings, suctioning or changing of the tracheostomy tube, and/or monitoring of unstable respiratory status (see Category 15—Suctioning).
2) Includes care of tracheostomy site.
q) Category 17—Discharge Planning
Type code: Intensity codes
A specific discharge plan has been developed by an interdisciplinary team and reflected in the resident care plan. Includes only residents with discharge anticipated within the next three (3) months to a less restrictive environment. This plan shall include family and other state agency programs where appropriate (i.e., Department on Aging and Department of Rehabilitation Services). Discharge of the resident need not be accomplished provided the plan has been implemented and the services were within the past six months.

r) Category 18—Health and Fitness Programs
Type code: Intensity Codes.
A health and fitness program has been specifically planned for the resident by a licensed nurse. The fitness program is written on the resident's fitness card. Following the resident's attendance, participation in the specific routine(s) must be recorded on the resident's fitness card. The program is carried out at least three times per week. The resident's response to the program must be documented in the clinical record one time per month. Fitness routines should vary based on the resident's physical condition, fitness preferences and plan of care. Programs may be self-monitored. Programs may consist of, but are not limited to walking/fitness trails, flexibility exercises, endurance maintenance, wheel chair pushups, swimming, biking, basketball, baseball, and/or volleyball.

s) Category 19—Restraint Management and Reduction
Base Rate Services
The resident does not have an assessed need to be physically restrained because of a continuing health, functional or psychosocial condition. A physical restraint may be used temporarily to provide necessary life saving treatment, if there are medical symptoms which are life threatening. A physical restraint may be used for brief periods to allow medical treatment to proceed if there is documented evidence of the resident's or legal representative's approval of the temporary physical restraint. If a temporary physical restraint is needed because of medical symptoms which are life threatening, documented attempts at less restrictive measures prior to application of the physical restraint are not required.
Type Code: Intensity Codes
The resident has been assessed by licensed staff and, for clearly documented reasons which are not life threatening, has been determined to be in need of a physical restraint, the resident, family (if appropriate), guardian or legal representative has consented to the use of the physical restraint. The staff has attempted less restrictive measures and documented the results. Consultation has taken place with appropriate health professionals, such as physician, occupational therapist, physical therapist or rehab certified registered nurse, in the use of less
restrictive supportive devises or methods. Where appropriate, the less restrictive measures have been successfully maintained without the use of physical restraints. Where less restrictive measures have not been successful and physical restraints have been applied, the care plan documents the duration, type and circumstances under which the restraint can be used. The restraints are properly applied and the resident is released from the restraint, exercised or ambulated, and repositioned for at least 10 minutes at least every 2 hours, the interdisciplinary team reviewed the continuing need for restraints and that reduction in duration or less restrictive measures have been discussed. As the interdisciplinary team determines, an individualized restraint reduction program is developed and implemented.

1) **Category—Social Services**  
   1) **Type Code—Intensity Codes**  
      Resident and/or family and/or guardian counseled on residents rights at admission and reviewed individually with residents and/or family and/or guardian at least annually. Staff orients resident and/or family and/or guardian to facility programs, Medicare/Medicaid programs (including prevention of spousal impoverishment), advance directives, available medical services, community support services, and the resident's personal allowances initially and annually thereafter, and gives assistance to resident in applying for any needed services. Facility ascertains and arranges to secure or provide resident's choice of pastoral care. Resident and/or family and/or guardian are encouraged to participate in care plan conferences. Facility acquaints resident with resident council purpose/functions and encourages participation.

2) To qualify for Level 2, all Level 1 requirements must be in place as well as the following: Resident has participated in a monthly standard social service interview soliciting resident opinions and preferences about defined aspects of the quality of life in the facility. If resident is unable to participate in this interview, a family or guardian interview, in person or by phone, may be done on a monthly basis.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

**Section 147.75 Definitions (Repealed)**

"ADL." Activities of daily living.

"ADL Adaptive Equipment." ADL adaptive equipment refers to any device applied to the hand or arm that allows for independence in eating, grooming,
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writing, bathing, dressing.

"Agency Note." Clarification for Department staff and providers regarding interpretation of the administrative rule or interpretative guidelines.

"Ambulate." Process of moving from one place to another either on foot (with or without a device) or in a wheelchair or geri-chair.

"Assessment/Reassessment." The process of obtaining and interpreting data by licensed personnel. This data is gathered through record review, specific, direct observation, interview, and the administration of data collection procedures.

The requirement of an assessment/reassessment is indicated for several of the functional and/or service categories. Reference to an assessment does not mean the facility must develop a distinct assessment form for each category. Facilities should be encouraged to conduct a comprehensive assessment with emphasis given to the areas upon which resident programs or care plans will be based.

A reassessment does not require the completion of a new assessment duplicating the comprehensive assessment already conducted. A reassessment requires a focused review of the resident's current status, progress, the continual appropriateness of the program and/or care plan. The individual conducting the reassessment should document findings updating the initial assessment.

"Assistance." Assistance refers to hands-on services by a staff member to help a resident do something such as dress, eat, etc.

"Augmentative Communication Systems/Devices." Augmentative communication systems and devices encompass a broad range of unaided vs. aided communication systems. Examples of unaided modes of communications are gesturing, sign language, eye pointing and head nod/shake responses. Aided modes of communication may include the use of an eye gaze communication board or an electronic communication device that has speech output or a print tape.

"Base Rate Services." Denotes minimum standard services covered in the base rate.
"Certified Occupational Therapist Assistant/Licensed (COTA/L)." Has completed an occupational therapy program of at least two years in length leading to an associate degree or its equivalent approved by the Department of Professional Regulation (DPR) and has successfully completed the examination authorized by DPR (see Ill. Rev. Stat. 1989, ch. 111, pars. 3701 et seq.).

"Clinical Fellow" (CFY). The educational equivalent to a certified Speech-Language Pathologist/Audiologist. This entry level professional is engaged in completion of the Clinical Fellowship Year/CFY required for certification as a Speech-Language Pathologist/Audiologist.

"Clinical Record." Any document containing resident specific information. The clinical record includes information on the resident's current status, plans of care and resident's response to care. Flow sheets, treatment sheets and nurses' notes are all components of the clinical record. The clinical record is a permanent document.

"Dependent (totally)." Resident requires the activity of the given area of need to be administered and/or performed by the facility staff and the resident cannot perform the activity himself/herself.

"Fitness Card." A card which includes individual resident data along with planned activities, frequency of activities, necessary monitoring and documentation requirements.

"Flow Sheet." Specialized form designed for staff to record services and/or treatments delivered to residents on a regular basis. Flow sheets are a permanent part of the clinical record.

"Fluidotherapy." A multifunctional modality that simultaneously applies heat, massage, sensory stimulation and pressure oscillation through the use of pulverized corn husks. It is used to decrease pain and edema, increase range of motion and circulation, and heal open or closed wounds. Unlike water, the dry natural media does not irritate the skin or produce thermal shock.

"Intervention." Planned interactions requiring either hands on or verbal action by staff member. Actions are purposeful with the intent of altering or maintaining a resident's condition. Interventions are documented in resident's individualized plan of care.
"Kardex." A centralized source of information outlining the daily care needs of a resident. The entries made on this record are temporary and are updated as physician's orders or change in the resident's condition dictate. Its primary use is to provide a ready source of information for the direct care staff to use in planning for and prioritizing the resident's daily care.

"Less Restrictive Environment." Discharge to a less restrictive environment entails transfer of a resident from a skilled or intermediate care facility to a facility providing sheltered care or room and board; or discharge of a resident to home, independent living arrangement or residential rehabilitation facility or an ICF/ID.

"Monitor." Direct observation by staff of a resident for a specific purpose.

"Monthly." Thirty (30) consecutive days.

"Need Not Met." Objective criteria used to verify that services are not rendered and are not effective in meeting residents' needs.

"Normal operations of facility." Daily patterns of staff carrying out their prescribed duties or residents engaging in routine patterns of daily living.

"Occasional." Action that does not occur in a pattern. For example, a resident is occasionally incontinent when he/she due to medication, certain foods, excitement, etc, may have an accident. However, it is not a consistent pattern.

"Occupational Therapist Registered/Licensed (OTR/L)." A graduate of an occupational therapy program of at least four years in length leading to a baccalaureate degree or its equivalent approved by DPR and that person has successfully completed the examination authorized by DPR (see Ill. Rev. Stat. 1985, ch. 111, pars. 3701 et seq.).

"Off-hours." Refers to medication prescribed by the physician to be given at times other than the facilities routine times for dispensing medications. Off-hour medications should be given for specific purposes (i.e. eye drops, antibiotics, etc.) and should be of a limited duration.

"Paraffin Heat Therapy." A paraffin bath is wax which has been completely melted to 126° (F) – 130° (F). This treatment is used to apply heat uniformly to hand, foot, or other body areas to relieve pain, soreness and to relax muscle
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spasms. The heat relaxes the muscles and stimulates circulation of blood.

"Physical Restraints." Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Arm and leg restraints, hand mitts, soft ties or vests, wheelchair safety bars and geri-chairs are considered physical restraints.

"Physiatrist." A physician who has specialized in the field of physical, occupational and speech therapies and all exercise and heat modalities for treating orthopedic, neurological and circulatory disturbances.

"Physical Therapist (PT)." Is a person who has graduated from a curriculum in physical therapy approved by DPR and has passed an examination approved by the DPR to determine his fitness for practice as a physical therapist.

"Physical Therapist Assistant (PTA)." Is a person who has graduated from a two year college level program approved by the American Physical Therapy Association; or has two years of appropriate experience as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

"Psychotropic Drugs." Any drugs which are used for anti-psychotic, anti-depressant, anti-manic, sedative-hypnotic, and/or anti-anxiety purposes and which are intended to control mood, mental status or behavior of the resident.

"Qualified Health Professional (QHP)." An educator with a degree in education from an accredited program. A registered physical or occupational therapist. A physician licensed by the State of Illinois to practice medicine or osteopathy. A psychologist with a valid, current Illinois registration. A registered nurse with a valid, current Illinois registration. A registered speech pathologist or audiologist. A person with a Bachelor's Degree in one of the following areas of concentration: social work, applied sociology, applied psychology, or counseling and one year of health care experience in a health care setting. A therapeutic recreation specialist who is certified by the National Council for Therapeutic Recreation Certification. A rehabilitation counselor who is certified by the Committee on Rehabilitation Counselor Certification.

"Qualified Mental Health Professional (QMHP)." A person who has at least one year of experience working directly with persons with mental illness and is one of
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the following: a doctor of medicine or osteopathy; a registered nurse; a psychologist with at least a master's degree in psychology from an accredited school; or an individual who holds at least a bachelor's degree in one of the following professional categories: An occupational therapist or occupational therapy assistant certified by the American Occupational Therapy Association or other comparable body; A social worker with a bachelor's degree from a college or university or graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; A human services professional including, but not limited to: sociology, special education, rehabilitation counseling and psychology.

"Reassessment." See Assessment.

"Rehabilitation Nurse." A registered professional nurse who has successfully completed a course approved by the Department of Public Health or documents at least 60 hours of classroom/laboratory training in restorative/rehabilitative nursing. This training must be documented by a transcript, certificate, diploma or other written documentation from an accredited school or recognized accrediting agency such as a state or national organization of nurses or a state licensing authority.

"Rehabilitation services." Rehabilitation services are those related professional therapy services provided by or under the supervision of licensed, certified, or registered personnel, specifically designed for a particular resident to improve the resident's functional abilities. These programs must be individually developed, have the potential to benefit the resident, and be ordered by the resident's physician. At a minimum these services must be provided by a duly qualified, certified nurse's aide trained in a rehabilitation program approved by the Department of Public Aid. While there is no specific time limitation for their duration, improvement of the resident's condition should be evident in the resident's record.

"Restorative services." Restorative services are those medical and nursing treatments provided either by or under the supervision of licensed personnel specifically required to maintain or improve a resident's functional condition or prevent further deterioration. These procedures should be reviewed by the facility's interdisciplinary team at the time of the care plan review and incorporated into the care plan. Services can include passive range of motion, palliative skin care, positioning, bowel and bladder retraining, ambulation and ADL retraining.
"Skilled services."—Resident requires, on a daily basis, the direct observation, assistance, monitoring, or performance of nursing procedures by a registered nurse or the direct supervision by a registered nurse.

"Supervise."—The process of overseeing or directing either staff in the care of the resident or the resident him/herself in performing certain functional or medical tasks. In the case of residents, staff must be present either to instruct, prompt, or to make sure the resident carries out a specific task in such a manner as to complete the task or avoid injury. In the case of staff, it is either direct supervision or the giving of detailed verbal or written instructions on how to carry out a specific procedure for or on a resident.

"T.E.N.S. Unit."—Transcutaneous Electrical Nerve Stimulatory (used strictly for pain control).

"Transfer."—The process of physically moving a resident from one place to another.

"Verification of Level of Service."—Activity by the Department’s staff to verify that the level of service, as indicated by the facility, is both needed and received.

"Wheelchair Cuffs."—Leather cuffs for quads who need traction on wheelchair rims; fingerless leather with an abrasive strip.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.100 Reconsiderations (Repealed)

a) A facility may request a reconsideration of the resident assessment conducted by the Inspection of Care (IOC) team if the facility believes the assessment does not accurately reflect the level of need of its residents. The facility will be given the IOC assessments in batches of 20% as the case manager completes them for the purpose of allowing the facility time to review the assessment prior to the Exit Conference. Differences between the facility and the IOC team regarding level of need of the residents are to be addressed using a three-step approach:
   1) exit conference negotiation between the facility and IOC team;
   2) central office arbitration; and
   3) first level review.

b) At the exit conference the facility must state the functional and service needs that
it wishes to dispute. The facility is responsible for providing supporting data to the IOC team in an effort to reconcile the differences. When the differences are not reconciled through negotiation, the IOC team nurse will provide the facility with appeal/arbitration request forms on which the facility must record the level of service it believes accurately reflects the residents' needs. The nurse will automatically forward the appeal/arbitration request forms and supportive documentation provided by the facility to the central office for arbitration.

e) Arbitration is contingent upon exit conference negotiation and the submittal of the completed appeal arbitration request forms to the IOC team.

d) First level review is contingent upon the previous steps having been completed.

e) Final resolution of the reconsideration process shall be within 100 days of the date of the exit conference which constitutes the first step of the process.

f) Arbitration shall be completed by nurse and/or physician arbitrators, as indicated. Any information that was not presented at the exit conference will not be considered. Results of the arbitration will be communicated in writing to the facility within forty-five days after the exit conference. If the arbitration review does not resolve differences concerning disputed items to the facility's satisfaction, the facility must request, in writing, a first level review within ten days of receipt of the central office arbitration decision. Otherwise the reconsideration process will be completed without advancing to first level review.

g) First level review will be conducted by the Chief of the Bureau of Long-Term Care or designee. Any information that was not presented at the exit conference and/or the arbitration will not be considered. The Bureau Chief or designee will reverse the arbitrator's determination only if it is demonstrated that relevant evidence was not considered or finds the arbitrator's determination against the weight of the evidence. Results of the administrator's review and reasons, therefore, will be mailed to the facility within 45 days of receipt of the facility's request for first level review.

h) The Department reserves the right to examine the validity of all assessments. A reassessment may be conducted and will serve as the basis for the facility's program reimbursement for the rate period in question. The facility may request a review of this reassessment according to the specifications above. Such an examination may be triggered by but not limited to assessments resulting in a rate increase or decrease of ten or more percent.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.125 Nursing Facility Resident Assessment Instrument Times and Staff Levels
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a) Except as specified in subsection (b) of this Section, all Medicaid certified nursing facilities shall comply with the provisions of the current federal Long Term Care Resident Assessment Instrument User's Manual, version 2 (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002). This incorporation by reference includes no later amendments or editions.)

b) Nursing facilities shall, in addition, comply with the following requirements:

1) Complete a full Minimum Data Set (MDS) for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Sections T and U. RAPs and Sections T and U shall only be completed at admission, annually, for a significant change or for a significant correction of a prior MDS.

2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment. The rate set will be based on the MDS received two quarters prior to the rate effective date and MDS not received within 31 days will be given a default rate. a) This Section will become effective January 1, 1987. Section 140.904 will no longer be utilized for determining reimbursement rates as of January 1, 1987. b) This Section specifies how resident assessment scores are associated with the type and amount of staff time for the purposes of computing per diem reimbursement rates as defined in Section 147.150, Section 147.Table A, and Section 147.Table B of this rule. For each need level of nursing care, the number of minutes per day and the allocation of this time among the staff classifications nurse aide, licensed nurses, and therapist are stated. Staff time is presented in terms of minutes per day even though the service may not be provided daily. Thus, reimbursement for the service may be greater than might appear from the per diem amounts. For example, a score of 1 on the Bathing and Grooming item is associated with 12 minutes per day. If, as is typical, residents are bathed twice per week, this reimbursement supports 42 minutes per bath. Staff times include preparation for the service, talking with the resident during the care, the provision of the service, cleaning up, and charting.
Section 147.150  Minimum Data Set (MDS) Based Reimbursement System Statewide Rates

a) Public Act 92-0848 requires the Department to implement, effective July 1, 2003, a payment methodology for the nursing component of the rate paid to nursing facilities. Reimbursement for this component shall be calculated using the Minimum Data Set (MDS). Increased reimbursement under this payment methodology shall be paid only if specific appropriation for this purpose is enacted by the General Assembly.

b) The nursing component of the rate shall be calculated annually and may be adjusted quarterly. The determination of rates shall be based upon a composite of MDS data collected from each eligible resident in accordance with Section 147.Table A for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter. The nursing component of the rate may be adjusted on a quarterly basis if any of the following conditions are met:

1) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds total variable nursing time calculated for the previous rate quarter by more than five percent.

2) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds:

   A) total variable nursing time as calculated for the annual rate period by more than ten percent;

   B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

3) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No quarterly nursing component rate reduction shall exceed five percent from the
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previous rate quarter. a) This Section will become effective July 1, 1991 unless otherwise indicated.

Per diem reimbursement rates for nursing care in nursing intermediate and skilled care facilities consist of three six elements: variable time reimbursement, training time reimbursement, fixed time reimbursement, fringe benefit reimbursement, and reimbursement for allowable costs of supplies, consultants, medical directors and nursing directors, and therapies.

1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that which vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Section Sections 147.Table A and 147.Table B). Reimbursement is developed by multiplying the time for each service by the wage(s) of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. When a service can be provided by either a registered nurse (RN) or licensed practical nurse (LPN), the wage used will be weighted by the average mix of RNs and LPNs in the sample of facilities used to set rates. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner: A) Determination of wages. In calculating the rate, the figures used by the Department for "wages" will be determined in the following manner:

A) i) The mean wages for the applicable staff levels (RNs, LPNs, RN's, LPN's, certified nursing assistants (CNAs), activity staff, social workers, Nurse Aides), as reported on the cost reports and determined by regional rate area, geographical location will be the mean wages base.

B) ii) Fringe Effective September 1, 1993, fringe benefits will be the average percentage percent of benefits to actual salaries of all nursing facilities homes based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the base wage. iii) The fringe benefits will be added to the base.
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C)iv) The base wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected base wage changes.

D)v) Special minimum wage factor. The process used in subsection (c)(1)(A)(b)(1)(A)(i) of this Section to determine regional mean wages for RNs, LPNs, and CNAs will be modified. For the period beginning July 1, 1990, the Department will use the formula below to determine regional mean wages for RNs, LPNs, and CNAs. The formula below is applied to the base wage calculated in subsection (c)(1)(C) of this Section to determine regional mean wages for RNs, LPNs, and CNAs. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average. Effective July 1, 1990, through June 30, 1992, a final wage multiplier of 4.1% will be applied to wages. Beginning July 1, 1992 through August 31, 1993, a final wage multiplier of 6.2% will be applied to wages. Effective September 1, 1993, the wage multiplier is eliminated.

E) On July 1 of each year beginning July 1, 2003, the base wage calculated in subsection (c)(1)(C) of this Section shall be multiplied by a ratio:

i) The numerator of which is the quotient obtained by dividing the amounts estimated by the Department to be available in the rate period for the nursing component of the rate Statewide by the Department's estimate of the number of patient days Statewide for the rate period eligible for reimbursement from the Department.

ii) The denominator of which shall be the mean Statewide base rate per patient day.

B) Determination of Times and Staff Levels. The times and staff levels have been assigned by a panel of administrators and nurses active in long term care. Prior time/motion studies were used to assist the panel. These times will be reviewed periodically to insure that they accurately reflect nursing practice in the State.
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Time Reimbursement. Fixed or indirect nursing time is that time which does not vary with resident condition or which cannot be measured by an assessment tool. It includes such items as staff meetings, supervision, "downtime", checking physicians' orders and time spent with residents which does not vary with condition. A statewide sample of residents will be used to determine "fixed" time. The mean variable time will be computed for the sample for each level of care, and this amount subtracted from Department of Public Health Minimum Staffing Ratios plus 5% for each level of care. (Department of Public Health Minimum Staffing Ratios, which are measured in terms of time, can be found in 77 Ill. Adm. Code 1230). Once the "fixed" time has been determined, the minutes will be weighted at 20% licensed and 80% unlicensed time and multiplied by the appropriate wage. This amount will be added to variable time for each resident in the sample. If fixed time is less than zero minutes, then it will equal zero.

2) Vacation, Sick Leave and Holiday Time. The time to be added for vacation, sick leave, and holidays will be determined by multiplying the total sum of Variable and Fixed Time by 5%. This time will then be weighted by 80% unlicensed and 20% licensed wages to determine the amount to be added to the rate for these benefits.

3) Special Supplies, Consultants and the Director of Nursing. Reimbursement amounts will be made added for health care and program supplies, consultants required by the Department of Public Health (including the Medical Director), and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830).

A) Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). Health care and program salaries shall be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care.
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and programs salaries. A standard amount by level of care will be allocated for supplies. This amount will be determined based on the ratio of median updated supply costs by region to median costs for variable and fixed time by level of care (SNF/ICF) by region.

B) The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for the Director of Nursing and consultant costs shall be the Statewide mean of the ratio of all facilities Director of Nursing and consultant costs to total facility health care and programs salaries. The same analysis will be used to determine an amount for Consultants (including Medical Director) and the Director of Nursing. However, these costs will be updated with the wage-inflation rate.

C) These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).

Therapies:

A) Effective January 1, 1993 the Department will begin incorporating speech, occupational and physical therapy services and restorative program nursing assessments into the Inspection of Care (IOC) survey. B) In order to transition reimbursement for these services to the IOC, facilities currently providing these services will receive an add-on to the nursing component of its per diem. The add-on amount will be calculated by the Department and will be based on historical data from paid claims and adjustments. The add-on amount will begin with January 1993 services and will continue until the facility receives a new rate as a result of an IOC survey conducted in calendar year 1993.

d(e) Determination of Facility Rates.

1) The rate each facility receives will be determined by the assessed needs of residents the facility serves. Effective January 1, 1990, nurses from Department of Public Aid (DPA) will conduct an assessment of 100% of the Medicaid residents by level of care in each home annually. The assessment will be conducted during the four month period prior to the annual nursing IOC rate adjustment date. The needs of the residents in the sample will be assessed with the Resident Assessment Instrument. An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection (c)(b)(1) of this Section above), adding the appropriate amount for fixed time (see
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subsection (b)(3) above) and amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section (b)(4) above), and supplies, consultants, and the Director of Nursing, (see subsection (c)(3) of this Section (b)(5) above). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible Medicaid patient in the facility effective on the facility's annual nursing IOC rate adjustment date. 2) A copy of the Resident Assessment will be left with the facility upon completion.

e) A transition period from the payment methodology in effect on June 30, 2003, to the payment methodology in effect July 1, 2003, shall be provided for a period not exceeding June 30, 2005, as follows:

1) MDS-based rate adjustments under this Section shall not be effective until the attainment of a threshold. The threshold shall be attained at the earlier of either:

A) when all nursing facilities have established a rate (sum of all components) which is no less than the rate effective June 30, 2002, or

B) July 1, 2005.

2) For a facility that would receive a lower nursing component rate per resident day under the payment methodology effective July 1, 2003, than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be held at the level in effect on June 30, 2003, until a higher nursing component rate of reimbursement is achieved by that facility.

3) For a facility that would receive a higher nursing component rate per resident day under the payment methodology in effect on July 1, 2003, than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be adjusted based on the payment methodology in effect July 1, 2003.

4) Notwithstanding subsections (e)(2) and (3) of this Section, the nursing component rate per resident day for the facility shall be adjusted in accordance with subsection (c)(1)(E) of this Section. d) An interim IOC may be requested by a facility by notifying, in writing, the Bureau of Long Term Quality Care Bureau Chief within 180 days of the exit date of the
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last IOC. The following criteria shall be met before a request for an interim IOC can be made. A 25% or greater turnover in Medicaid residents since the last IOC or there has been a 7% or greater increase in the average per patient care time. The request for the interim IOC shall contain a full explanation of why the facility meets the criteria and must include any documentation relevant to the request. The facility will be notified within 45 days from the date the request is received of whether an interim IOC will be conducted. If approved, the Bureau will conduct a full IOC within 60 days of the written approval decision. Upon reassessment, an amended 2700 will be forwarded to the DPA. Upon receipt of the amended 2700 the facility's rate will become effective for the final six months of that facility's rate year. If the interim IOC is scheduled to take place during the period when the next annual IOC is scheduled, only one IOC will be done. The rate that results will apply for the 18 month period which begins with the effective date of the interim IOC rate.

(Source: Amended at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.175 Minimum Data Set (MDS) Integrity Referrals

a) The Department shall conduct reviews to determine the accuracy of resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. Such reviews may, at the discretion of the Department, be conducted electronically or in the facility.

b) The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews. In addition, the Department may select facilities for on-site review based upon facility characteristics, past performance, or the Department's experience.

c) Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.

d) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals.

1) On-site reviews may be conducted with respect to residents or facilities that are identified pursuant to subsection (b) or (c) of this Section. Such review may include, but shall not be limited to, the following:
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A) Review of resident records and supporting documentation to determine the accuracy of data relevant to the determination of reimbursement rates.

B) Review and collection of information necessary to assess the need for a specific service or care area and an extension beyond the established maximum length of time for a service or care area.

C) Review and collection of information from the facility that will establish the current direct care staffing level.

2) The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded.

3) Upon the conclusion of any review, the Department shall conduct a meeting with facility management to discuss preliminary conclusions of the review. If facility management disagrees with those preliminary conclusions, facility management may, at that time, provide additional documentation to support their position.

e) Corrective action. Upon the conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate.

1) Data Accuracy.

A) Final conclusions with respect to inaccurate data shall be referred to the Department of Public Health.

B) The Department, in collaboration with the Department of Public Health, shall make available additional training in the completion of resident assessments and the coding and transmission of MDS records.

2) Recalculation of Reimbursement Rate. The Department shall determine if reported MDS data or facility staffing data that were subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data. No change in reimbursement required as a result of a review shall take effect before July 1, 2004. A facility's rate will be subject to change if: 
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A) The recalculation of the direct care component rate, as a result of using MDS data that are verifiable:

i) Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

ii) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

iii) Decreases the rate by more than ten percent in addition to the rate change specified in subsection (d)(1)(C) of this Section. The direct care component of the rate shall be reduced, retroactive to the beginning of the rate period, by $1 for each whole percentage decrease in excess of ten percent.

B) The review determines that the mean direct care staff time per diem that the facility is currently maintaining is more than 25 percent below the mean direct care staff time per diem used to determine the facility's direct care component of the rate. The recalculation shall use the mean direct care staff time per diem determined pursuant to Section 147.150(c)(1), multiplied by the factor described in Section 147.150(c)(1)(D), less mean direct care staff time per diem determined by the review that is in excess of 25 percent.

3) Any evidence or suspicion of deliberate falsification or misrepresentation of MDS data shall be referred to the Department's Inspector General and the Department of Public Health.

f) Appeals. Facilities disputing any rate change may request a hearing pursuant to 89 Ill. Adm. Code 140.830. a) Facility and/or physician referral shall be made for each resident with a service and/or functional need unmet. b) A written facility response is required for each facility referral received. c) The facility response shall be forwarded to the Case Manager within 15 days of the Inspection of Care survey. d) The facility response must address categories of service and/or functional needs unmet and must address each resident's service and/or functional need unmet.
Section 147.200 Basic Rehabilitation Aide Training Program (Repealed)

a) Prior to a resident being given credit on the Illinois Assessment of Needs (DPA 2700) for occupational rehabilitation level one (see Section 147.50(j)(1)(A)) and/or physical rehabilitation level one (see Section 147.50(k)(1)(A)), the rehabilitation aide providing the service must meet one of the following conditions:

1) Successful completion (score of 75% or more) of the Occupational or Physical Rehabilitation Aide Proficiency Examination administered by the Illinois Department of Public Aid (IDPA) in October 1986 for the area in which the aide is to be employed; or

2) Successful completion of an IDPA approved 24 hour Occupational or Physical Rehabilitation Aide Training Program for the area in which the aide is to be employed; or

3) Be a nurse licensed under the Illinois Nursing Act [225 ILCS 65] who has received a "Certificate of Completion" from a rehabilitation or restorative nursing course.

b) Course Prerequisites

1) Occupational Rehabilitation Aide (ORA).
   A) Certified Nurse Aide (CNA) (see 77 Ill. Adm. Code 395.300); or
   B) Developmental Disabilities Aide (see 77 Ill. Adm. Code 395.310); or
   C) Basic Child Care/Habilitation Aide (see 77 Ill. Adm. Code 395.320); or
   D) Registered Nurse (RN) or Licensed Practical Nurse (LPN).

2) Physical Rehabilitation Aide (PRA).
   A) Certified Nurse Aide (see 77 Ill. Adm. Code 395.300); or
   B) Registered Nurse (RN) or Licensed Practical Nurse (LPN); or
   C) Developmental Disabilities Aide (see 77 Ill. Adm. Code 395.310); or
   D) Basic Child Care/Habilitation Aide (see 77 Ill. Adm. Code 395.320).

c) Criteria for an IDPA Approved Basic Rehabilitation Aide Training Program are as follows:

1) Application Procedures:
The following information must be furnished to the Department at least 60 days in advance of the training program. Each program sponsor providing
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its own training must apply for individual program approval. Retroactive approval will not be granted.

A) Program rationale, i.e., philosophy, purpose and brief summary of the identified sponsoring agency and faculty qualifications.

B) Complete outline which specifies program title, objectives, content, and methodology delineated by hour. The instructor has flexibility of teaching content in desired outline.

C) Location and scheduled dates of program (including future dates). If programs are canceled or rescheduled for any reason, the Department must be notified prior to delivery date for purposes of monitoring.

D) A copy of the evaluation tool for participant use must be included. The evaluation tool must evaluate the objectives, content, and instructors.

2) Submitted materials will be reviewed by the Department and the program sponsor will be notified of the Department's action. Approval will be based upon the compliance of the submitted materials with the requirements of this section. If the program is not approved, the reason for this decision will be given to the program sponsor.

3) If a program is not approved, the program sponsor may, after making the appropriate modifications, reapply for approval.

4) Orientation to the specific policies of the employing agency shall be in addition to the 24 hours of instruction.

5) Any change in content, objectives, or instructional staff must be submitted for review.

6) All approved training programs must be resubmitted prior to 30 days of the annual anniversary date of the program's approval for continued approval. In the resubmission process, the program sponsor must submit the information specified in subsection (c)(1) above. Approval will be based upon compliance of the submitted materials with the requirements of this Section. In the resubmissions process, the program sponsor shall refer to the number assigned by the Department.

7) Each instructor is to provide ten questions with answers that cover the course content. The questions and answers will become a bank of questions and answers which will be developed into a non-credit post-examination. This examination will be given by the instructor upon completion of the course to evaluate the effectiveness of training and demonstrate the students competency to the instructor.

d) Instructor Qualifications and Requirements

1) The Occupational Rehabilitation Aide Training Program Instructor shall
be a registered occupational therapist with a current Illinois license (see 225 ILCS 75) who has no other duties during the hours while engaged in instruction of the training program, and who has had a minimum of three years experience with at least two years experience working with geriatrics in a non-acute setting.

2) The Physical Rehabilitation Aide Training Program Instructor shall be a physical therapist with a current or pending Illinois license (see 225 ILCS 90) who has no other duties during the hours while engaged in instruction of the training program, and who has had a minimum of three years experience with at least two years experience working with geriatrics in a non-acute setting.

3) Instructor vitae must be submitted and a copy of his or her current license or verification from the Department of Registration and Education of pending licensure.

d) Course Requirements

1) The basic content must be presented in a minimum time frame of three days but not to exceed a maximum of 21 days unless it is being done by an educational institution (e.g., four year college or university, two year community college, or vocational school) on a term, semester or trimester basis. A ratio of two hours of didactic instruction to one hour of experiential learning exercises must be reflected in the 24 hours minimum of training. Term, semester and trimester courses may be submitted by an educational institution. The program must include designated hours for each method of teaching.

2) The Basic Occupational Rehabilitation Aide Training Program shall include at a minimum:

A) Module I: Purpose and philosophy.
   i) Define the objectives of the occupational rehabilitation program. Upon completion of this unit of instruction, the student will be able to: Differentiate among habilitation, rehabilitation, and occupational therapy; and understand the philosophy of habilitation, rehabilitation and occupational therapy.
   
   ii) Identify the concepts of rehabilitation. Upon completion of this unit of instruction, the student will be able to:
   
   Discriminate rehabilitation from restorative measures; identify purpose of the restorative measures; identify purpose of rehabilitation measures; and list four compensatory techniques.

   iii) Understand the relationship of occupational rehabilitation
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to other long-term care facility departments. Upon completion of this unit of instruction, the student will be able to: Match the department name with a description of its function; and list three forms of communication used by the facility to develop an interdisciplinary approach to resident care.

iv) Understand standards of conduct with residents, family, friends, and other staff. Upon completion of this unit of instruction, the student will be able to: Define the purpose of confidentiality; identify appropriate responses to be used with family and friends of residents; identify appropriate responses to resident's behavior; understand need for separation of work and home life; understand the difference between empathy and sympathy; understand ethical responsibility; define fraud; and examine methods to be used to deal with situations that may require applications of ethical responsibility.

B) Module II: Overview of policies.

i) Understand procedures pertaining to occupational rehabilitation. Upon completion of this unit of instruction, the student will be able to: Define the characteristics of appropriate candidates; and understand general admission and discharge criteria.

ii) Understand program documentation requirements. Upon completion of this unit of instruction, the student will be able to: Identify the role of documentation; have an awareness of techniques used in screening and assessment; define common medical terminology and abbreviations; read an evaluation and treatment plan; identify components of care plans; and explain ORA's methods of communication of information to the OTR/L.

C) Module III: Specific occupational rehabilitation techniques.

i) Develop an awareness of the physical component skills necessary to carry out ADL tasks. Upon completion of this unit of instruction, the student will be able to: Define and describe physical deficits that lead to ADL dysfunction, namely cardiovascular accident, arthritis, Parkinson's, multiple sclerosis, diabetes, fractures and amputations, Alzheimer's disease and related disorders, and developmental disabilities; and have had an opportunity to
experience procedures and suggested activities used for remediation and compensation for physical deficits.

ii) Develop an awareness of the sensory problems that lead to ADL dysfunction. Upon completion of this unit of instruction, the student will be able to: Define and describe sensory deficits that lead to ADL dysfunction, namely cardiovascular accident, arthritis, Parkinson's, multiple sclerosis, diabetes, fractures and amputations, Alzheimer's disease and related disorders, and developmental disabilities; have had an opportunity to experience procedures and suggested activities used for remediation and compensation of sensory loss; and expand his or her knowledge of techniques used by the ORA to improve the resident's functioning and compensate for loss of function or to adapt to permanent loss.

iii) Develop an awareness of perceptual and integration components that lead to ADL dysfunction. Upon completion of this unit of instruction, the student will be able to: Have an awareness of perceptual and integrative deficits that lead to ADL dysfunction, namely body image and scheme, agnosia, apraxias, figure and ground, midline, preservation, and sequencing; and have had an opportunity to experience procedures and suggested activities used for remediation and compensation of perceptual and integrative dysfunction.

iv) Develop an awareness of cognitive deficits that lead to ADL dysfunction. Upon completion of this unit of instruction, the student will be able to: Identify components of cognition, namely memory, attention span, ability to learn new tasks, problem solving, and judgment; and have had an opportunity to experience procedures and suggested activities used for remediation and compensation for ADL dysfunction.

v) Develop an understanding of the role that motivation and interest play in the rehabilitation process. Upon completion of this unit of instruction, the student will be able to: Identify techniques used to gain and hold the resident's interest; and identify techniques used to motivate the resident.
vi) Understand the deficits of disease, disability and the aging process. Upon completion of this unit of instruction, the student will be able to: Describe and identify symptomatology of the following conditions - arthritis, Parkinson's, multiple sclerosis, diabetes, fractures and amputations, Alzheimer's disease and related disorders, and developmental disabilities; and have had an opportunity to experience procedures, adaptation techniques, equipment and environment to enhance independence in ADLs related to enhancing deficit areas.

vii) Learn body mechanics and methods of positioning residents. Upon completion of this unit of instruction, the student will be able to: Demonstrate principles of proper positioning in bed, chair and standing; and demonstrate principles of repositioning and moving residents.

viii) Understand expected behaviors and responsibilities related to emergency procedures. Upon completion of this unit of instruction, the student will be able to: Identify the ORA's role with regard to falls, fractures, fires, catheter bags and infection control; and list the adverse symptoms that should caution the ORA.

D) Module IV: Psychological concepts.

i) Identify stereotypes and myths of the aged/chronically disabled. Upon completion of this unit of instruction, the student will be able to: Define aging; define chronic dysfunctional process; and discriminate myths and stereotypes from reality.

ii) Recognize the multiple problems of the aged and chronically disabled. Upon completion of this unit of instruction, the student will be able to: Identify types of problems facing the elderly in nursing homes; and identify types of problems facing the disabled in nursing homes.

iii) Understand one's own personal attitudes regarding the elderly and chronically disabled. Upon completion of this unit of instruction, the student will be able to: Discuss how attitudes and values effect expectations of achievement.

iv) Identify Kubler Ross' stages of death and dying and how they relate to loss. Upon completion of this unit of instruction, the student will be able to: List the five stages of the grieving process; and discuss ways to deal with the
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resident's behavior in each stage.

v) Understand how physical, emotional, psychological losses lead to depression and decreased function. Upon completion of this unit of instruction, the student will be able to: Identify losses that occur in aging; and identify losses that occur in chronic illness.

vi) Understand self esteem and those factors which effect positive and negative motivation. Upon completion of this unit of instruction, the student will be able to: Identify factors that influence motivation positively; identify factors that influence motivation negatively; and recognize impact that a care giver can have on the resident's self esteem.

3) The Basic Physical Rehabilitation Aide Training Program shall include at a minimum:

A) Module I—Philosophy and purpose.

i) Define the role of restorative nursing in long-term care. Upon completion of this unit of instruction, the student will be able to: Discern the difference between restorative nursing and physical rehabilitation; and define the role of the nursing assistant in restorative care.

ii) Define the role of physical rehabilitation programs in long-term care. Upon completion of this unit of instruction, the student will be able to: Define the role of the Physical Rehabilitation Aide; and identify the acceptable parameters of practice for the Physical Rehabilitation Aide, i.e., no manual stretching, no manual resistance.

iii) Identify the effects of aging. Upon completion of this unit, the student will be able to: Understand the normal aging process; understand the chronic pathophysiological process; and discriminate myths and stereotypes of aging.

iv) Identify the goals/objectives of physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Identify modalities used in physical rehabilitation to improve functional abilities; identify methods used to upgrade gross motor function; identify methods used to assist a resident to develop alternative methods of mobility; will be able to demonstrate methods used to improve safety during application of functional mobility techniques.

v) Identify the benefits of rehabilitation and restorative
services. Upon completion of this unit of instruction, the student will be able to: Experience techniques that can be used to motivate a resident to achieve the highest level of function; identify methods to use in providing emotional support; increase awareness of the role of rehabilitation and restorative services in improving the resident's self-image; and understand the role these services play in encouraging participation in activities, socialization and vocational programs.

vi) Identify the PRA's expected attitudes and standards of conduct. Upon completion of this unit of instruction, the student will be able to: State the consequences of falsifying records; discuss methods to deal with situations where the PRA may be asked to falsify records; understand consequences of practicing outside the realm of their duties, i.e., doing assessments, reassessments and evaluations of residents; demonstrate methods to be used to maintain modesty and dignity of residents; understand the PRA's role in maintaining confidentiality; and understand and respect the resident's rights.

B) Module II: Terminology and abbreviations.
   i) Standard medical terminology used in physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Define the standard terms used in physical rehabilitation; and read and understand a physical therapist's assessment and progress notes.
   ii) Standard medical abbreviations used in physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Translate abbreviations; and to read and understand a physical therapist's assessment, i.e., identification of problems, goals, approaches and programs.

C) Module III: Disease process.
   i) Identify the major neuromuscular disorders encountered in physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Identify the major characteristics of a resident with status post CVA, multiple sclerosis and Parkinson's disease; experience methods used to provide physical rehabilitation services to residents with these conditions; and identify precautions to be observed when delivering services to these clients.
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ii) Identify the major musculoskeletal disorders encountered in physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Identify the major characteristics of a resident with fractures, amputations of limbs, osteoporosis, arthritis; experience methods used to provide physical rehabilitation services to residents with these conditions; and identify precautions to be observed when delivering services to these clients.

iii) Understand the basic body responses of a person with cardiopulmonary disease to physical rehabilitation. Upon completion of this unit of instruction, the student will be able to: Identify the impact on an impaired cardiopulmonary system when subjected to physical rehabilitation; experience methods used to provide physical rehabilitation services to residents with these conditions; and identify precautions to be observed when delivering services to these clients.

iv) Identify the neurological disorders encountered in physical rehabilitation: Identify the major characteristics of a resident with Alzheimer's disease, epilepsy and organic brain syndrome; experience methods used to provide physical rehabilitation services to residents with these conditions; and identify precautions to be observed when delivering services to these clients.

f) To evaluate the effectiveness of the Basic Rehabilitation Aide Training in educating the trainees, upon completion of the training program, each participant must take a non-credit post test that encompasses the didactic and experiential learning opportunities presented. The Department will provide a post-test that shall be developed from questions submitted by licensed occupational and physical therapists who have received IDPA approval for rehabilitation aide courses. A summary of post-test scores must be returned to the Department. The instructor shall submit for validation only those certificates of students who the instructor feels have demonstrated competency.

g) The Illinois Department of Public Aid shall monitor the training program. If the program, approved pursuant to subsection (c)(3) of this Section, is not being delivered, program approval will be rescinded.

h) Certificates

1) Proof of successful completion of the approved program necessitates the sponsoring organization to award certificates to the trainees. The following information must be sent to the Department prior to the
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Department validating the certificates:
A) Evidence of successful completion of the designated course, i.e., the certificate,
B) A list of the names of attendees,
C) A list of social security numbers of the attendees,
D) Course completion date,
E) Program approval number,
F) The CNA's certificate, or
G) Proof of credentials other than the CNA certificate, that qualify the student to be a candidate.

2) The Department will not validate a certificate for the following reasons:
A) If the trainee lacks the prerequisites specified in subsection (b) of this Section, or
B) If the trainee has been found guilty of abuse, neglect, or theft, based upon information on the Illinois Department of Public Health Nurse Aide Registry.

3) The Department will return the validated certificates to the sponsor(s) for distribution. The following minimum information must be typed on the certificates before they are sent to the Department for validation:
A) Name of trainee and social security number.
B) Title: Basic Occupational or Physical Rehabilitation Training Program, as appropriate.
C) Candidate qualifications, e.g., CNA, Developmental Disabilities Aide (see subsection (b) of this Section).
D) Identification number of the program.

4) Successful completion of the course does not imply "certification" of the rehabilitation aide by the State. It only indicates that the person has successfully completed the Basic Rehabilitation Aide Training Program. Services provided by this individual to Medicaid recipients living in licensed long term care facilities may be eligible for reimbursement so long as the individual possesses a validated certificate from the IDPA and all of Section 147.50 pertaining to this subsection (h)(4) is adhered to (see Sections 147.50(j)(1)(A) and 147.50(k)(1)(A)).

i) Requests for approval of programs and other related correspondence are to be submitted to the Bureau of Long Term Quality Care.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.205 Nursing Rates (Repealed)
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For residential nursing services provided to Medicaid residents in skilled and intermediate care facilities from January 1, 1989, unless otherwise indicated, the Department will determine nursing rates according to the following steps:

a) Calculation of the nursing rate: For each facility, the nursing rate will be computed according to the methods specified in Section 147.150(b), employing reimbursable staff times as specified in Section 147. Tables A and B for all assessment items.

b) Calculation of the final nursing rate: For each facility, a final nursing rate will be equal to the sum of the nursing rate (see subsection (a) above) plus an add on for Care Planning equal to $.45 per resident day, statewide. Effective July 1, 1992 and ending August 31, 1993, there will be an additional wage adjuster add-on of $1.58 per resident day for geographic areas that have wages equal to or above the Statewide average and $2.00 per resident day for geographic areas that have wages below the Statewide average. Effective September 1, 1993, the wage adjuster add-on will be eliminated.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)

a) Reimbursement for Comprehensive Resident Assessment
   1) Variable Time Reimbursement:
      A) Effective July 1, 1990, nursing facilities will be reimbursed for the new variable time service category, comprehensive resident assessment. For the reimbursement year July 1, 1990 through June 30, 1991, reimbursement of this service item will cover the period October 1, 1990 (the effective date of the new federal regulation) through June 30, 1991. Starting with July 1, 1991, the reimbursement will cover the full reimbursement year.

      B) For the reimbursement period of July 1, 1990 until the nursing facility’s first annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, the associated per diem per resident amounts of staff time and staff levels for this category of service shall be: one minute of nurse aide time; 2.2 minutes of licensed nurse time; 1.4 minutes of registered nurse time; and .6 minutes of social worker time.

      C) When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update, as specified in subsection
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(a)(1)(A) above, reimbursement for this category of service will be based on individual resident need assessments from the resident assessment instrument (42 CFR 483.20(b)(1)(i)) and will be determined on an individual facility basis. The per diem per resident amounts of staff time and staff levels associated with resident assessment scores for this new category of service item which will be used in the individual facility determination of reimbursement are located in Section 147. Table A.

2) Determination of Facility Rate:
   A) For the reimbursement period July 1, 1990, through June 30, 1991, the per diem reimbursement amounts for comprehensive patient assessment shall be calculated by multiplying the number of reimbursement staff minutes for this category of service item by the statewide average per minute staff wages, and further multiplying this amount by .75 in order to prorate the nine month per diem amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year.

   B) For the reimbursement period of July 1, 1990 until the nursing facility's first annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, the prorated per diem per resident amount for comprehensive patient assessment shall be added to the facility's new computed nursing rate as described in Section 147.205(c).

   C) When individual facilities have their annual Inspection of Care nursing reimbursement rate update, as specified in subsection (a)(2)(B) above, the prorated per diem amount for comprehensive patient assessment calculated for each resident will be added to the other amounts calculated for the assessed needs of the resident and the facility rate will then be determined as specified in Section 147.150(c)(1).

   D) Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for comprehensive patient assessment shall cover the full twelve months of the reimbursement year.

b) Reimbursement of Social Services
   1) Effective July 1, 1990, nursing facilities will be reimbursed for social services. The reimbursement level of this service item will cover the nine month period from October 1, 1990 through June 30, 1991, for the
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reimbursement year July 1, 1990, through June 30, 1991. Starting July 1, 1991, the reimbursement level will be for a full twelve month reimbursement year.

2) For the reimbursement period of July 1, 1990, until the nursing facility's annual inspection of care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem reimbursement for social work services will be based on the ratio of total social work wage costs to the total nursing wage costs for the facilities in the state. The actual social work and nursing wage costs facilities report in the cost reports will be used in obtaining a statewide ratio, unless the nursing facility reports no social work wage costs or the facility has 120 or more beds and it reports annualized paid and accrued social work hours of less than 2080 hours. In the case of no social work wage costs reported, the facility's data will be excluded in deriving the statewide ratio. For a facility with 120 or more beds, the social work hours to be used in deriving the wage costs will be the greater of the reported paid and accrued social work hours or the annual 2080 hour standard adjusted to the length of the facility's cost report period.

3) For the reimbursement period July 1, 1990 through June 30, 1991, the social work to nursing cost statewide ratio derived in subsection (b)(2) above will be multiplied by .75 in order to prorate the nine month per diem reimbursement amount to be paid over the full twelve months of the July 1, 1990 through June 30, 1991 reimbursement year. Effective July 1, 1991, the proration will be discontinued and the reimbursement for social services shall cover the full twelve months of the reimbursement year.

4) The statewide ratio will be applied to the statewide average per diem per resident nursing care time cost amount (staff minutes multiplied by per minute wage) obtained from the resident assessments to derive the per diem per resident social service reimbursement which shall be added to the facility's new computed nursing rate described in Section 147.205(c).

e) Reimbursement for Registered Nurse Coverage

1) Effective July 1, 1990, nursing facilities will be reimbursed for additional registered nurse coverage costs to meet the requirements of maintaining registered nurse coverage eight hours per day seven days a week (42 CFR 483.30). The reimbursement of these additional costs will cover a nine month period for the July 1, 1990 through June 30, 1991 reimbursement year. Starting July 1, 1991, the reimbursement will cover a full twelve month period.

2) For the reimbursement period of July 1, 1990 until the nursing facility's
annual Inspection of Care nursing reimbursement rate update resulting from an annual Inspection of Care assessment occurring on or after January 1, 1991, a statewide per diem per resident reimbursement for additional RN coverage costs will be derived based on the ratio of total additional RN coverage costs to total nursing wage costs for the facilities.

3) The additional costs for RN coverage costs will be derived as follows:
   A) If a nursing facility reports no registered nurse salary costs in the cost report and the average hourly wages for the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are less than the average hourly registered nurse (RN) wage for the region, the annual RN salary cost will be determined by multiplying an annual 2912 hour RN coverage standard by the average hourly RN wage for the region. The amount will be adjusted to the length of the facility's cost report period to obtain the additional salary costs for RN coverage. If either the DON or the ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage equal to or above the average hourly RN wage will be deducted from the 2912 hour standard used in deriving the annual salary cost for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.
   B) If a nursing facility reports RN salary costs and the annualized paid and accrued hours are below the 2912 hour standard, the difference between the annualized paid and accrued hours and the 2912 hour standard will be determined. If either the DON or ADON average hourly wages are equal to or above the average hourly RN wage for the region, the annualized DON and ADON hours paid and accrued at a wage level equal to or above the average hourly RN wage for the region will be deducted from the hour difference. The balance of hours will be multiplied by the average hourly RN wage for the region and the product will be adjusted to the length of the facility's cost report period to obtain the facility's additional salary cost for RN coverage. If the balance of hours is equal to or less than zero, the facility's additional salary cost for RN coverage will be zero.
   C) For the reimbursement period July 1, 1990 through June 30, 1991, the additional salary costs for RN coverage obtained in subsection (b)(2)(A) or (B) above will be multiplied by .75 in order to prorate the nine month reimbursement to be paid over the full twelve
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months of the reimbursement year. For the year beginning July 1, 1991, the proration will be discontinued and the reimbursement for additional RN coverage shall cover the full twelve months of the reimbursement year.

D) The statewide per diem reimbursement for additional RN coverage costs will be based on the ratio of the total additional RN coverage salary costs obtained from subsection (c)(3)(C) above to the statewide total nursing wage costs for the facilities.

E) The resulting statewide ratio will be applied to the statewide average per diem per resident nursing care time cost amount (staff minutes multiplied by per minute wages) obtained from the resident assessments for the facilities to derive the statewide per diem per resident RN coverage reimbursement which shall be added to the facility's new computed nursing rate as described in subsection 147.205(e).

d) Variable Time Reimbursement for Social Services and Registered Nurse Coverage

1) Variable Time Reimbursement

A) When individual nursing facilities have their annual Inspection of Care nursing reimbursement rate update, as specified in subsections (b)(2) and (c)(2) above, the statewide approach to per diem reimbursement for social services and additional RN coverage costs will be discontinued. Reimbursement for these areas will be converted to new variable time service categories; social services; continence restorative; specialized medication monitoring; restraint management and reduction; and communication.

B) Per diem per resident reimbursement for these new categories of service items will be based on individual resident need assessments from the resident assessment instrument and will be determined on an individual facility basis. The per diem per resident amounts of staff time and staff levels associated with resident assessment scores for this new category of service item which will be used in the individual facility determination of reimbursement are located in Section 147. Table A.

2) Determination of Facility Rate:

A) For the reimbursement period specified in subsection (d)(1)(A) above through June 30, 1991, the per diem reimbursement amounts for social services, continence restorative, specialized medication monitoring, restraint management and reduction, and communication shall be calculated for each resident by multiplying
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the number of reimbursable staff minutes for these category of service items by the appropriate staff wages (as derived according to Section 147.150(b)(1)(A), and further multiplying these amounts by .75 in order to prorate the nine month per diem amounts to be paid over a twelve month period.

B) The prorated per diem amounts for these new variable time category of service items calculated for each resident will be added to the other per diem amounts calculated for the assessed needs of the resident and the facility rate will then be determined as specified in Section 147.150(c)(1).

C) Effective July 1, 1991, the proration of a nine month reimbursement to be reimbursed over a twelve month period will be discontinued and the reimbursement amounts for these new variable time category of service items shall cover the full twelve months of the reimbursement year.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level

a) Effective July 1, 2003, each Medicare and Medicaid certified nursing facility shall complete, and transmit quarterly to the Department, a full Minimum Data Set (MDS) for each resident who resides in a certified bed, regardless of payment source. A description of the MDS items referenced in the tables found following subsection (e) of this Table A are contained in the Long Term Care Resident Assessment Instrument User's Manual available from the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002).

b) Table A identifies 37 MDS items that shall be used to calculate a profile on each Medicaid-eligible resident within each facility.

c) The profile for each Medicaid-eligible resident shall then be blended to determine the nursing component of the nursing facility’s Medicaid rate.

d) Each MDS item in Table A includes a description of the item and the variable time referred to in Section 147.150(c)(1). The variable time assigned to each level represents the type of staff that should be delivering the service (unlicensed, licensed, social worker and activity) and the number of minutes allotted to that service item.
e) Following is a listing of the 37 reimbursable MDS items found in Table A.

1) Base Social Work and Activity

2) Activities of Daily Living (ADL)

3) Restorative Programs
   - PROM
   - AROM
   - Splint/Brace
   - Bed Mobility
   - Mobility/Transfer
   - Walking
   - Dressing/Grooming
   - Eating
   - Prosthetic Care
   - Communication
   - Other Restorative
   - Continence

4) Medical Services
   - Discharge Planning
   - End Stage Care
   - Pain Management
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NOTICE OF ADOPTED AMENDMENTS

Infectious Disease

Acute Medical Conditions

Nutrition

Skin Care Programs

Decubitus Prevention

Moderate Skin Intensity or Ostomy Care Services

Intensive Skin Care Services

IV Therapy

Injections

Oxygen Therapy

Extensive Respiratory Services

Hydration

5) Mental Health (MH) Services

Psychosocial Adaptation

Cognitive Impairment/Memory Assistance

Psychiatric Rehabilitation

6) Special Patient Need Factors:

Communication: add 1% of staff time accrued for ADLs through MH

Vision Problems: add 2% of staff time accrued for ADLs through MH
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NOTICE OF ADOPTED AMENDMENTS

**Accident/Fall Prevention:** add 3% of staff time accrued for ADLs through MH

**Restraint Free Care:** add 2% of staff time accrued for ADLs through MH

**Activities:** add 2% of staff time accrued for ADLs through MH

MDS ITEMS AND ASSOCIATED STAFF TIMES

1) **Base Social Work and Activity**

<table>
<thead>
<tr>
<th>Level</th>
<th>All Clients</th>
<th>Unlicensed</th>
<th>Licensed</th>
<th>Social Worker</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

2) **Activities of Daily Living**

<table>
<thead>
<tr>
<th>Level</th>
<th>Composite Scores</th>
<th>Unlicensed</th>
<th>Licensed</th>
<th>Social Worker</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Composite 7-8</td>
<td>50</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Composite 9-11</td>
<td>62</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Composite 12-14</td>
<td>69</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Composite 15-29</td>
<td>85</td>
<td>25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADL Scoring Chart for the above Composite Levels

MDS values equal to “-” denote missing data.

<table>
<thead>
<tr>
<th>ADL</th>
<th>MDS items</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
<td>G1aA = - or</td>
<td>Self-Performance = missing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G1aA = 0 or</td>
<td>Self-Performance = independent</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>G1aA = 1.</td>
<td>Self-Performance = supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G1aA = 2.</td>
<td>Self-Performance = limited assistance</td>
<td>3</td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

| G1aA = 3 or G1aA = 4 or G1aA = 8 AND G1aB = - or G1aB = 0 or G1aB = 1 or G1aB = 2. | Self-Performance = extensive assistance  
|                                                                                   | Self-Performance = total dependence  
|                                                                                   | Self-Performance = activity did not occur  
| G1aB = 3 or G1aB = 8.                                                            | Support = missing  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Transfer | G1bA = - or G1bA = 0 or G1bA = 1. | Self-Performance = missing  
|          | G1bA = 2.                                                                   | Self-Performance = independent  
|          | G1bA = 3 or G1bA = 4 or G1bA = 8 AND G1bB = - or G1bB = 0 or G1bB = 1 or G1bB = 2. | Self-Performance = supervision  
|          | G1bB = 3 or G1bB = 8.                                                        | Self-Performance = limited assistance  
|          | Support = no set up or physical help  
|          | Support = set up help only  
|          | Support = 1 person assist  
|          | Support = 2+ person physical assist  
|          | Support = activity did not occur  

| Locomotion | G1eA = - or G1eA = 0 or G1eA = 1. | Self-Performance = missing  
|           | G1eA = 2.                                                                  | Self-Performance = independent  
|           |                                                                           | Self-Performance = supervision  
|           |                                                                           | Self-Performance = limited assistance  

| Support = missing  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Support = no set up or physical help  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Support = no set up or physical help  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Support = no set up or physical help  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Support = no set up or physical help  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

| Support = no set up or physical help  
| Support = set up help only  
| Support = 1 person assist  
| Support = 2+ person physical assist  
| Support = activity did not occur  

## DEPARTMENT OF PUBLIC AID

### NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self-Performance</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1eA = 3 or</td>
<td>Self-Performance = extensive assistance</td>
<td></td>
</tr>
<tr>
<td>G1eA = 4 or</td>
<td>Self-Performance = total dependence</td>
<td></td>
</tr>
<tr>
<td>G1eA = 8 AND</td>
<td>Self-Performance = activity did not occur</td>
<td></td>
</tr>
</tbody>
</table>
| G1eB = - or | Support = missing | 4  
| G1eB = 0 or | Support = no set up or physical help |  
| G1eB = 1 or | Support = set up help only |  
| G1eB = 2.  | Support = 1 person assist |  
| G1eB = 3 or| Support = 2+ person physical assist | 5  
| G1eB = 8.  | Support = activity did not occur |  

### Toilet

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self-Performance</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1iA = - or</td>
<td>Self-Performance = missing</td>
<td></td>
</tr>
</tbody>
</table>
| G1iA = 0 or | Self-Performance = independent | 1  
| G1iA = 1. | Self-Performance = supervision |  
| G1iA = 2.  | Self-Performance = limited assistance | 3  
| G1iA = 3 or| Self-Performance = extensive assistance |  
| G1iA = 4 or| Self-Performance = total dependence |  
| G1iA = 8 AND | Self-Performance = activity did not occur |  
| G1iB = - or | Support = missing | 4  
| G1iB = 0 or | Support = no set up or physical help |  
| G1iB = 1 or | Support = set up help only |  
| G1iB = 2.  | Support = 1 person assist |  
| G1iB = 3 or| Support = 2+ person physical assist | 5  
| G1iB = 8.  | Support = activity did not occur |  

### Dressing

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self-Performance</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1gA = - or</td>
<td>Self-Performance = missing</td>
<td></td>
</tr>
</tbody>
</table>
| G1gA = 0 or | Self-Performance = independent | 1  
| G1gA = 1. | Self-Performance = supervision |  
| G1gA = 2.  | Self-Performance = limited assistance | 2  
| G1gA = 3 or| Self-Performance = extensive assistance |  
| G1gA = 4 or| Self-Performance = total dependence | 3  
| G1gA = 8.  | Self-Performance = activity did not occur |  

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NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Hygiene</th>
<th>( G_1A = - ) or ( G_1A = 0 ) or ( G_1A = 1 )</th>
<th>Self-Performance = missing</th>
<th>( G_1A = 2 )</th>
<th>Self-Performance = limited assistance</th>
<th>( G_1A = 3 ) or ( G_1A = 4 ) or ( G_1A = 8 )</th>
<th>Self-Performance = extensive assistance</th>
</tr>
</thead>
</table>

Eating

<table>
<thead>
<tr>
<th>Eating</th>
<th>( G_1hA = - ) or ( G_1hA = 0 ) or ( G_1hA = 1 )</th>
<th>Self-Performance = missing</th>
<th>( G_1hA = 2 )</th>
<th>Self-Performance = limited assistance</th>
<th>( G_1hA = 3 ) or ( G_1hA = 4 ) or ( G_1hA = 8 )</th>
<th>Self-Performance = extensive assistance</th>
</tr>
</thead>
</table>

Or

<table>
<thead>
<tr>
<th>Intake = 1</th>
<th>Parenteral/IV in last 7 days</th>
<th>Tube feeding in last 7 days</th>
<th>See below</th>
</tr>
</thead>
</table>

Where

Intake = 1 if

<table>
<thead>
<tr>
<th>K6a = 3 or K6a = 4</th>
<th>Parenteral/enteral intake 51-75% of total calories</th>
<th>Parenteral/enteral intake 76-100% of total calories</th>
</tr>
</thead>
</table>

Or Intake = 1 if

| K6a = 2 and K6b =2 | Parenteral/enteral intake 25-50% of total calories | Average fluid intake by IV or tube is 501-1000 cc/day |
DEPARTMENT OF PUBLIC AID

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K6b =3 or
Average fluid intake by IV or tube is 1001-1500 cc/day
K6b =4 or
Average fluid intake by IV or tube is 1501-2000 cc/day
K6b =5. Average fluid intake by IV or tube is over 2000 cc/day

3) Restorative Programs

Passive Range of Motion

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>G4aA &gt; 0 or</td>
<td>Any function limits in ROM of neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4bA &gt; 0 or</td>
<td>Any function limits in ROM of arm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4cA &gt; 0 or</td>
<td>Any function limits in ROM of hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4dA &gt; 0 or</td>
<td>Any function limits in ROM of leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4eA &gt; 0 or</td>
<td>Any function limits in ROM of foot</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4fA &gt; 0 or</td>
<td>Any function limits in ROM of other limitation or loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4aB &gt; 0 or</td>
<td>Any function limits in voluntary movement of neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4bB &gt; 0 or</td>
<td>Any function limits in voluntary movement of arm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4cB &gt; 0 or</td>
<td>Any function limits in voluntary movement of hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4dB &gt; 0 or</td>
<td>Any function limits in voluntary movement of leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4eB &gt; 0 or</td>
<td>Any function limits in voluntary movement of foot</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>G4fB &gt; 0 or</td>
<td>Any function limits in voluntary movement of other limitation or loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AND

| I   | 3 ≤ P3a ≤ 5 | 3 to 5 days of PROM rehab | 10  | 6  |    |     |
| II  | 6 ≤ P3a ≤ 7 | 6 to 7 days of PROM rehab | 15  | 6  |    |     |

Active Range of Motion

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>G4aA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G4bA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of arm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G4cA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G4dA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G4eA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of foot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>G4fA,B &gt; 0 or</td>
<td>Any function limits in voluntary ROM or movement of other limitation or loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AND

| I   | 3 ≤ P3b ≤ 5 | 3 to 5 days of AROM rehab | 10  | 6  |    |     |
| II  | 6 ≤ P3b ≤ 7 | 6 to 7 days of AROM rehab | 15  | 6  |    |     |

Splint/Brace Assistance

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3 ≤ P3c ≤ 5</td>
<td>3 to 5 days of assistance</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6 ≤ P3c ≤ 7</td>
<td>6 to 7 days of assistance</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Bed Mobility Restorative

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 &lt; G1aA &lt; 8</td>
<td>Need assistance in bed mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And G7 = 1</td>
<td>Some or all ADL tasks broken into subtasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>3 ≤ P3d ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6 ≤ P3d ≤ 7</td>
<td>6 to 7 days of rehab or restorative techniques</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Mobility (Transfer) Restorative

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 &lt; G1bA &lt; 8</td>
<td>Need assistance in transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And G7 = 1</td>
<td>Some or all ADL tasks broken into subtasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>3 ≤ P3e ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6 ≤ P3e ≤ 7</td>
<td>6 to 7 days of rehab or restorative techniques</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Walking Restorative

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 &lt; G1cA &lt; 8</td>
<td>Any function limits in walking in room</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 &lt; G1dA &lt; 8</td>
<td>Any function limits in walking in corridor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 &lt; G1eA &lt; 8</td>
<td>Any function limits in locomotion on unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

| 0 < G1fA < 8 or | Any function limits in locomotion off unit |
| And G7 = 1     | Some or all ADL tasks broken into subtasks |
| AND            |                                             |

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3 ≤ P3f ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6 ≤ P3f ≤ 7</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
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</tbody>
</table>

**Dressing/Grooming Restorative**

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3 ≤ P3g ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>6 ≤ P3g ≤ 7</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Eating Restorative**

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3 ≤ P3h ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
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</table>
### Prosthetic Care

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3 ≤ P3i ≤ 5</td>
<td>3 to 5 days of assistance</td>
<td>10</td>
<td>6</td>
<td></td>
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</tr>
<tr>
<td>II</td>
<td>6 ≤ P3i ≤ 7</td>
<td>6 to 7 days of assistance</td>
<td>15</td>
<td>6</td>
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### Communication Restorative

<table>
<thead>
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<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>C4 &gt; 0</td>
<td>Deficit in making self understood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>3 ≤ P3j ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
<td></td>
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</tr>
<tr>
<td>II</td>
<td>6 ≤ P3j ≤ 7</td>
<td>6 to 7 days of rehab or restorative techniques</td>
<td>15</td>
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### Other Restorative

<table>
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<tr>
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<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Q1c= 1 or 2</td>
<td>Stay projected to be within 90 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And Q2 &lt; 2</td>
<td>Improved or no change in care needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And P1ar = 1</td>
<td>Provide training to return to community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>3 ≤ P3k ≤ 5</td>
<td>3 to 5 days of rehab or restorative techniques</td>
<td>10</td>
<td>6</td>
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</table>
### NOTICE OF ADOPTED AMENDMENTS

| II | 6 ≤ P3k ≤ 7 | 6 to 7 days of rehab or restorative techniques | 15 | 6 |

#### Continence

<table>
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<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>H3a = 1</td>
<td>Any scheduled toileting plan</td>
<td>22</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And (H1b &gt; 1 or G1iA &gt; 1)</td>
<td>Incontinent at least 2 or more times a week</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Self-Performance = limited to total assistance</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>II</td>
<td>H3b = 1 and H1b &gt; 1</td>
<td>Bladder retraining program</td>
<td>22</td>
<td>8</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>OR</td>
<td>Incontinent at least 2 or more times a week</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>H3b = 1 and (H1b ≤ 1 and H4 = 1)</td>
<td>Bladder retraining program for one quarter</td>
<td>22</td>
<td>8</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Residents continence has improved in last 90 days</td>
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#### 4) Medical Services

#### Discharge Planning

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<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Q1c= 1 or 2</td>
<td>Stay projected to be within 90 days</td>
<td>16</td>
<td>16</td>
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<tr>
<td></td>
<td>And Q2 &lt; 2</td>
<td>Improved or no change in care needs</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>And P1ar = 1</td>
<td>Provide training to return to community</td>
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#### End Stage Care
## Pain Management

<table>
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<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>J5c = 1</td>
<td>End stage disease, 6 or fewer months to live</td>
<td>10</td>
<td>12</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Restoratives set to level ‘0’ except AROM, PROM, Splint/Brace; limit of 4 quarters</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>J2a &gt; 0</td>
<td>Demonstrate or complain of pain</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>And J2b &gt; 1</td>
<td>Moderate to excruciating intensity</td>
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## Infectious Disease

<table>
<thead>
<tr>
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<th>MDS items</th>
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<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>I2a = 1 or</td>
<td>Antibiotic resistant infection</td>
<td>18</td>
<td>17</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>I2b = 1 or</td>
<td>Clostridium Difficile</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>I2i = 1 or</td>
<td>TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2k = 1 or</td>
<td>Viral Hepatitis</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>I2e = 1 or</td>
<td>Pneumonia</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>I2g = 1 or</td>
<td>Septicemia</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>I2l = 1 or</td>
<td>Wound Infection</td>
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<tr>
<td></td>
<td>I3 = ICD9 code 041.01,133.0</td>
<td>Streptococcus Group A, Scabies</td>
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</table>

## Acute Medical Conditions

<table>
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<tr>
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<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>J5b = 1 and</td>
<td>Acute episode or flare-up of chronic condition</td>
<td>1</td>
<td>23</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

- **P1ae = 1 and Monitoring acute medical condition**
- **P1ao = 0 or Not Hospice care**
- **(J5a = 1 and Condition makes resident’s cognitive, ADL, mood or behavior patterns unstable**
- **P1ao = 0 and Not Hospice care**
- **P1ae = 1) and Monitoring acute medical condition**
- **(B5a = 2 or Easily distracted over last 7 days**
- **B5b = 2 or Periods of altered perceptions or awareness of surroundings over last 7 days**
- **B5c = 2 or Episodes of disorganized speech over last 7 days**
- **B5d = 2 or Periods of restlessness over last 7 days**
- **B5e = 2 or Periods of lethargy over last 7 days**
- **B5f = 2) Mental function varies over course of day in last 7 days**

### Nutrition

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>K5h = 1</td>
<td>On a planned weight change program</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>K5b = 1 and</td>
<td>Tube feeding in last 7 days</td>
<td>0</td>
<td>22</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Intake = 1</td>
<td>See below</td>
<td>Intake = 1 if</td>
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DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>K6a</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 3</td>
<td>Parenteral/enteral intake 51-75% of total calories</td>
</tr>
<tr>
<td>= 4</td>
<td>Parenteral/enteral intake 76-100% of total calories</td>
</tr>
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</table>

Or Intake = 1 if

<table>
<thead>
<tr>
<th>K6a</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 2</td>
<td>Parenteral/enteral intake 25-50% of total calories</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>K6b</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 2</td>
<td>Average fluid intake by IV or tube is 501-1000 cc/day</td>
</tr>
<tr>
<td>= 3</td>
<td>Average fluid intake by IV or tube is 1001-1500 cc/day</td>
</tr>
<tr>
<td>= 4</td>
<td>Average fluid intake by IV or tube is 1501-2000 cc/day</td>
</tr>
<tr>
<td>= 5</td>
<td>Average fluid intake by IV or tube is over 2000 cc/day</td>
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</tbody>
</table>

Skin Care Programs – only the highest qualifying level of the moderate skin intensity or intensive skin care applies

Decubitus Prevention

<table>
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<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3</td>
<td>= 1 or</td>
<td>History of resolved ulcers in last 90 days</td>
<td>15</td>
<td>8</td>
<td></td>
<td></td>
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</tbody>
</table>

Any two of:

| M5a  | Pressure relieving device(s) for chair         |
| M5b  | Pressure relieving device(s) for bed           |
| M5c  | Turning or repositioning program               |
| M5d  | Nutrition or hydration intervention for skin    |
| M5i  | Other prevention for skin (other than feet)    |
## Moderate Skin Intensity Services or Ostomy Care Services

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M1a&gt; 0 or</td>
<td>Stage 1 ulcers</td>
<td>5</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M1b&gt; 0 or</td>
<td>Stage 2 ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any of:</td>
<td>Other Skin Problems (below):</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M4a</td>
<td>Abrasions, bruises</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>M4b</td>
<td>Burns</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>M4c</td>
<td>Open lesions other than ulcers</td>
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<td></td>
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<tr>
<td></td>
<td>M4d</td>
<td>Rashes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>M4e</td>
<td>Skin desensitized to pain or pressure</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>M4f</td>
<td>Skin tears or cuts (other than surgery)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M4g</td>
<td>Surgical wounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>And any of:</td>
<td>Skin Treatments (below):</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M5a</td>
<td>Pressure relieving device(s) for chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5b</td>
<td>Pressure relieving device(s) for bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5c</td>
<td>Turning or repositioning program</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M5d</td>
<td>Nutrition or hydration intervention for skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5e</td>
<td>Ulcer care</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M5f</td>
<td>Surgical wound care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5g</td>
<td>Application of dressings(other than feet)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5h</td>
<td>Application of ointments(other than feet)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5i</td>
<td>Other prevention for skin (other than feet)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
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</tbody>
</table>
NOTICE OF ADOPTED AMENDMENTS

(M6b = 1 or
M6c = 1) and
M6f = 1 or
P1af = 1

Provide ostomy care in last 14 days

Set Intensive Skin Care Services to zero

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>M1c &gt; 0 or</td>
<td>Stage 3 ulcers</td>
<td>5</td>
<td>30</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M1d &gt; 0</td>
<td>Stage 4 ulcers</td>
<td></td>
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<tr>
<td></td>
<td>and any of:</td>
<td>Skin Treatments (below):</td>
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</tr>
<tr>
<td></td>
<td>M5a</td>
<td>Pressure relieving device(s) for chair</td>
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<tr>
<td></td>
<td>M5b</td>
<td>Pressure relieving device(s) for bed</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M5c</td>
<td>Turning or repositioning program</td>
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<tr>
<td></td>
<td>M5d</td>
<td>Nutrition or hydration intervention for skin</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5e</td>
<td>Ulcer care</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>M5f</td>
<td>Surgical wound care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M5g</td>
<td>Application of dressings (other than feet)</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>M5h</td>
<td>Application of ointments (other than feet)</td>
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</tr>
<tr>
<td></td>
<td>M5i</td>
<td>Other prevention for skin (other than feet)</td>
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Set Moderate Skin Intensity Services to zero
### NOTICE OF ADOPTED AMENDMENTS

#### IV Therapy

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<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P1ac = 1 or K5a = 1</td>
<td>IV medication in last 14 days, Nutrition via parenteral/IV in last 7 days</td>
<td>9</td>
<td>30</td>
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</table>

#### Injections

<table>
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<tr>
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<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>O3 &gt; 0</td>
<td>Number of injections in last 7 days</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Oxygen Therapy

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P1ag = 1</td>
<td>Oxygen therapy administered in last 14 days</td>
<td>9</td>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Extensive Respiratory Services

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>P1ai = 1 or P1aj = 1</td>
<td>Performed suctioning in last 14 days, Administered tracheostomy care in last 14 days</td>
<td>15</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Hydration

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H2b = 1 or</td>
<td>Constipation</td>
<td>15</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Any two of:
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ≤ O4e ≤ 7</td>
<td>Received a diuretic medication in last 7 days</td>
</tr>
<tr>
<td>I3 a,b,c,d,e = 276.5</td>
<td>Volume depletion, dehydration</td>
</tr>
<tr>
<td>J2j = 1</td>
<td>Urinary Tract Infection in last 30 days</td>
</tr>
<tr>
<td>J1c = 1</td>
<td>Dehydrated</td>
</tr>
<tr>
<td>J1d = 1</td>
<td>Did not consume most fluids provided (3 days)</td>
</tr>
<tr>
<td>J1h = 1</td>
<td>Fever</td>
</tr>
<tr>
<td>J1j = 1</td>
<td>Internal bleeding</td>
</tr>
<tr>
<td>And K5a,b = 0</td>
<td>Not have parenteral /IV or feeding tube</td>
</tr>
</tbody>
</table>

5) Mental Health Services – only the highest qualifying score of the three services applies

Psychosocial Adaptation Services

<table>
<thead>
<tr>
<th>Level</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>(P2a = 1 or P2b = 1 or P2c = 1) and P2d = 1) and Any E1a-p &gt; 1 or F1g = 1 or Any F2a-g = 1 or Any F3a-c = 1</td>
<td>Behavior symptom evaluation Evaluation by licensed MH specialist within last 90 days Group therapy Resident specific changes to environment Indicators of depression No indicators of psychosocial well –being Any unsettled relationships Issues with past roles</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

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| E4aA > 0 or | Wandering in last 7 days |
| E4bA > 0 or | Verbally abusive in last 7 days |
| E4cA > 0 or | Physically abusive in last 7 days |
| E4dA > 0 or | Inappropriate or disruptive behavior in last 7 days |
| E4eA > 0 or | Resisted care in last 7 days |

**Cognitive Impairment/Memory Assistance Services**

<table>
<thead>
<tr>
<th>Lev</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>Cognitive Performance Scale of $\geq 3$</td>
<td>16</td>
<td>6</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>III</td>
<td>Cognitive Performance Scale of $\geq 5$</td>
<td>21</td>
<td>11</td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>

**Cognitive Performance Scale Codes**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Intact</td>
</tr>
<tr>
<td>1</td>
<td>Borderline Intact</td>
</tr>
<tr>
<td>2</td>
<td>Mild Impairment</td>
</tr>
<tr>
<td>3</td>
<td>Moderate Impairment</td>
</tr>
<tr>
<td>4</td>
<td>Moderate Severe Impairment</td>
</tr>
<tr>
<td>5</td>
<td>Severe Impairment</td>
</tr>
<tr>
<td>6</td>
<td>Very Severe Impairment</td>
</tr>
</tbody>
</table>

**Impairment Count for the Cognitive Performance Scale**

<table>
<thead>
<tr>
<th>I code</th>
<th>MDS items</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B2a = 1</td>
<td>Memory problem</td>
</tr>
<tr>
<td>IC 1</td>
<td>B4 = 1 or 2</td>
<td>Some dependence in cognitive skills</td>
</tr>
<tr>
<td>IC 2</td>
<td>$1 \leq C4 \leq 3$</td>
<td>Difficulty finding words to rarely or never understood</td>
</tr>
</tbody>
</table>

Note: None of B2a, B4, or C4 can be missing
### Severe Impairment Count for the Cognitive Performance Scale

<table>
<thead>
<tr>
<th>I code</th>
<th>MDS items</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Note: None of B2a, B4, or C4 can be missing</td>
</tr>
<tr>
<td>SIC 0</td>
<td>Below not met</td>
<td></td>
</tr>
<tr>
<td>SIC 1</td>
<td>B4 = 2</td>
<td>Moderately impaired in cognitive skills</td>
</tr>
<tr>
<td>SIC 2</td>
<td>C4 = 2 or 3</td>
<td>Sometimes understood to rarely or never understood</td>
</tr>
</tbody>
</table>

### Cognitive Performance Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>MDS items</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma</td>
<td>N1a = 0 and</td>
<td>Awake all or most of the time in the morning</td>
</tr>
<tr>
<td></td>
<td>N1b = 0 and</td>
<td>Awake all or most of the time in the afternoon</td>
</tr>
<tr>
<td></td>
<td>N1c = 0 and</td>
<td>Awake all or most of the time in the evening</td>
</tr>
<tr>
<td></td>
<td>B1 = 1 and</td>
<td>Is comatose</td>
</tr>
<tr>
<td></td>
<td>G1aA = 4 or 8 And</td>
<td>Bed-Mobility Self-Performance = total dependence or did not occur</td>
</tr>
<tr>
<td></td>
<td>G1bA = 4 or 8 And</td>
<td>Transfer Self-Performance = total dependence or did not occur</td>
</tr>
<tr>
<td></td>
<td>G1hA = 4 or 8 And</td>
<td>Eating Self-Performance = total dependence or did not occur</td>
</tr>
<tr>
<td></td>
<td>G1iA = 4 or 8 And</td>
<td>Toilet Use Self-Performance = total dependence or did not occur</td>
</tr>
<tr>
<td></td>
<td>Not (B4 = 0, 1, 2)</td>
<td>Not have cognitive skills independent to moderately impaired</td>
</tr>
<tr>
<td>6</td>
<td>B4 = 3 And</td>
<td>Cognitive skills severely impaired</td>
</tr>
<tr>
<td></td>
<td>G1hA = 4 or 8</td>
<td>Eating Self-Performance = total dependence or did not occur</td>
</tr>
<tr>
<td>5</td>
<td>B4 = 3 And</td>
<td>Cognitive skills severely impaired</td>
</tr>
<tr>
<td></td>
<td>G1hA = - or ≤ 3</td>
<td>Eating Self-Performance = missing to extensive assistance</td>
</tr>
<tr>
<td>4</td>
<td>If IC code = 2 or 3</td>
<td>Some dependence in cognitive skills</td>
</tr>
<tr>
<td></td>
<td>And SIC code = 2</td>
<td>Difficulty finding words to rarely or never understood</td>
</tr>
<tr>
<td>3</td>
<td>If IC code = 2 or 3</td>
<td>Some dependence in cognitive skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficulty finding words to rarely or never understood</td>
</tr>
</tbody>
</table>
NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>And SIC code = 1</th>
<th>Moderately impaired in cognitive skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>If IC code = 2 or 3</td>
<td>Some dependence in cognitive skills</td>
</tr>
<tr>
<td></td>
<td>Difficulty finding words to rarely or never understood</td>
</tr>
</tbody>
</table>

| 2 | And SIC code = 0 | Better than moderate cognition skills and usually can be understood |
| 1 | If IC code = 1 | Memory problem |

**Psychiatric Rehabilitation Services**

<table>
<thead>
<tr>
<th>Lev</th>
<th>MDS items</th>
<th>Description</th>
<th>Unl</th>
<th>Lic</th>
<th>SW</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>I1dd = 1 or</td>
<td>Anxiety Disorder</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1ff = 1 or</td>
<td>Manic depression (bipolar)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1gg = 1 or</td>
<td>Schizophrenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>J1e =1 or</td>
<td>Delusions in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>J1i = 1</td>
<td>Hallucinations in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>If above And</td>
<td></td>
<td>24</td>
<td>12</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>E4aA &gt; 0 or</td>
<td>Wandering in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E4bA &gt; 0 or</td>
<td>Verbally abusive in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E4cA &gt; 0 or</td>
<td>Physically abusive in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E4dA &gt; 0 or</td>
<td>Inappropriate or disruptive behavior in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E4eA &gt; 0 or</td>
<td>Resisted care in last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**6) Special Patient Need Factors**

**Communication**

<table>
<thead>
<tr>
<th>Count</th>
<th>MDS items</th>
<th>Description</th>
<th>Staff Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>C4 &gt; 0 or</td>
<td>Deficit in making self understood</td>
<td>1% of all staff time accrued in all categories from ADLs through Mental Health</td>
</tr>
<tr>
<td></td>
<td>C6 &gt; 0</td>
<td>Deficit in understanding others</td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID
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**Vision Problems**

<table>
<thead>
<tr>
<th>Count</th>
<th>MDS items</th>
<th>Description</th>
<th>Staff Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>D1 &gt; 0 or</td>
<td>Vision impaired to Severely impaired</td>
<td>2% of all staff time accrued in all categories from ADLs through Mental Health</td>
</tr>
<tr>
<td></td>
<td>D2a = 1 or</td>
<td>Decreased peripheral vision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D2b = 1</td>
<td>Experience halos around lights, light flashes</td>
<td></td>
</tr>
</tbody>
</table>

**Accident/Fall Prevention**

<table>
<thead>
<tr>
<th>Count</th>
<th>MDS items</th>
<th>Description</th>
<th>Staff Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>G3a &gt; 0 or</td>
<td>Unable to maintain position as required for balance test while standing</td>
<td>3% of all staff time accrued in all categories from ADLs through Mental Health</td>
</tr>
<tr>
<td></td>
<td>G3b &gt; 0 or</td>
<td>Unable to maintain position as required for balance test while sitting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>J4a = 1 or</td>
<td>Fell in past 30 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>J4b = 1 or</td>
<td>Fell in past 31 – 180 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>J1n = 1 or</td>
<td>Has unsteady gait</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E4aA &gt; 0</td>
<td>Wandered in last 7 days</td>
<td></td>
</tr>
</tbody>
</table>

**Restraint Free**

<table>
<thead>
<tr>
<th>Count</th>
<th>MDS items</th>
<th>Description</th>
<th>Staff Minutes</th>
</tr>
</thead>
</table>
**DEPARTMENT OF PUBLIC AID**

**NOTICE OF ADOPTED AMENDMENTS**

<table>
<thead>
<tr>
<th></th>
<th>In last assessment:</th>
<th>And in current assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P4c &gt; 1 or</strong></td>
<td>Used trunk restraint daily in last 7 days</td>
<td>Not used trunk restraint in last 7 days</td>
</tr>
<tr>
<td><strong>P4d &gt; 1 or</strong></td>
<td>Used limb restraint daily in last 7 days</td>
<td>Not used limb restraint in last 7 days</td>
</tr>
<tr>
<td><strong>P4e &gt; 1</strong></td>
<td>Used chair that prevents rising daily in last 7 days</td>
<td>Not used chair that prevents rising in last 7 days</td>
</tr>
</tbody>
</table>

**Activities**

<table>
<thead>
<tr>
<th>Count</th>
<th>MDS items</th>
<th>Description</th>
<th>Staff Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N2 = 0 or 1 and</td>
<td>Involved in activities more than ⅓ of time</td>
<td>2% of all staff time accrued in all categories from ADLs through Mental Health</td>
</tr>
<tr>
<td></td>
<td>(G6a = 1 or C4 &gt; 1 or C6 &gt; 1 or)</td>
<td>Bedfast all or most of the time</td>
<td>2% of all staff time accrued in all categories from ADLs through Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes or rarely or never understood</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sometimes or rarely or never understands others</td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1o (&gt; 0) or</td>
<td>Withdraws from activities of interest more than 5 days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>((AA3-A3a) / 365.25 \leq 50) or</td>
<td>Resident is 50 years of age or younger at the time of the assessment reference date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1p (&gt; 0) or</td>
<td>Reduced social interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4aA (&gt; 0) or</td>
<td>Wandering in last 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4bA (&gt; 0) or</td>
<td>Verbally abusive in last 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4cA (&gt; 0) or</td>
<td>Physically abusive in last 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4dA (&gt; 0) or</td>
<td>Inappropriate or disruptive behavior in last 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4eA (&gt; 0) or</td>
<td>Resisted care in last 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4bB (&gt; 0) or</td>
<td>Limited ROM voluntary movement of arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4cB (&gt; 0) or</td>
<td>Limited ROM voluntary movement of hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G4dB (&gt; 0) or</td>
<td>Limited ROM voluntary movement of leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E2 (&gt; 0) and ((E1a (&gt; 0) or Made negative statements)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>((E1a (&gt; 0) or</td>
<td>Made negative statements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1n &gt; 0 or</td>
<td>Makes repetitive physical movements</td>
</tr>
<tr>
<td>E4eA &gt; 0 or</td>
<td>Resisted care in last 7 days</td>
</tr>
<tr>
<td>E1o &gt; 0 or</td>
<td>Withdraws from activities of interest more than 5 days a week</td>
</tr>
<tr>
<td>E1p &gt; 0 or</td>
<td>Reduced social interaction</td>
</tr>
<tr>
<td>E1j &gt; 0 or</td>
<td>Unpleasant mood in morning more than 5 days a week</td>
</tr>
<tr>
<td>N1d &gt; 0 or</td>
<td>Not awake all or most of the time</td>
</tr>
<tr>
<td>N1a,b,c ≤ 1 and</td>
<td>Not awake all or most of the time</td>
</tr>
<tr>
<td>B1 = 0) or</td>
<td>Not comatose</td>
</tr>
<tr>
<td>E1g &gt; 0 or</td>
<td>Repeated statements that something terrible will happen</td>
</tr>
<tr>
<td>K3a = 1</td>
<td>Weight loss (5% in 30 days or 10% in 180 days)</td>
</tr>
</tbody>
</table>

a) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on January 1, 1991 through June 30, 1991.

<table>
<thead>
<tr>
<th>Item</th>
<th>Level</th>
<th>Time</th>
<th>Allocation</th>
<th>Staff Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing, Grooming</td>
<td>0</td>
<td>6</td>
<td>Nurse Aide</td>
<td>Nurse Aide</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>12</td>
<td>Nurse Aide</td>
<td>Nurse Aide</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>22</td>
<td>Nurse Aide</td>
<td>Nurse Aide</td>
</tr>
<tr>
<td>Clothing</td>
<td>0</td>
<td>4</td>
<td>Nurse Aide</td>
<td>Nurse Aide</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>10</td>
<td>Nurse Aide</td>
<td>Nurse Aide</td>
</tr>
</tbody>
</table>
## NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Item</th>
<th>Level</th>
<th>Time</th>
<th>Allocation</th>
<th>Staff Type</th>
</tr>
</thead>
<tbody>
<tr>
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**Agency Note:** Level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.
b) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on July 1, 1991 through December 31, 1992.

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DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Agency Note: level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.

e) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on or after January 1, 1993.

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**NOTICE OF ADOPTED AMENDMENTS**

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DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
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Agency Note: level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.

(Source: Amended at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE B Staff Time and Allocation for Restorative Programs (Repealed)

Table B refers to Section 147.25, "Restorative Care"

a) The following reimbursement times, allocations, and need levels, apply for all reimbursement periods commencing on January 1, 1991 through June 30, 1991.

<table>
<thead>
<tr>
<th>Item</th>
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</tr>
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</tr>
<tr>
<td></td>
<td>2</td>
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<tr>
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<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>2</td>
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<td>18/2</td>
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<td>0</td>
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<td>Nurse Aide/Licensed Staff</td>
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DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

<table>
<thead>
<tr>
<th>Item</th>
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<th>Time</th>
<th>Allocation</th>
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Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.

b) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on July 1, 1991 through December 31, 1992.

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<tr>
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<td></td>
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Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.
DEPARTMENT OF PUBLIC AID

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e) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on or after January 1, 1993.

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</tr>
<tr>
<td>Eating</td>
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Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147. TABLE C Comprehensive Resident Assessment (Repealed)

a) Verification of Level of Service
A comprehensive resident assessment must be completed within 14 days of admission or, in the case of a significant change in resident condition, as soon as the resident stabilizes at a new functional or cognitive level or within 14 days, whichever is earlier and must be repeated no less often than every 12 months from the date of the last full comprehensive resident assessment. A comprehensive care plan must be developed within seven days of completion of the comprehensive resident assessment and updated every 90 days or sooner if the resident has experienced a significant change in status. The interdisciplinary team must
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examine each resident no less than once every 90 days and, as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment. A resident would score on this level if two or more full comprehensive assessments were necessary and completed in the past year because of a significant change in the resident condition.

b) Needs Not Met
1) Comprehensive resident assessment not completed within 14 days of admission or, in the case of a significant change in condition, as soon as the resident stabilizes at a new functional or cognitive level or within 14 days, whichever is earlier.
2) Comprehensive resident assessment not completed within 12 months from the date of the last comprehensive resident assessment.
3) Care plan not developed by interdisciplinary team within seven days of completion of the comprehensive resident assessment or care plan not updated every 90 days or sooner if the resident has experienced a significant change in status.
4) Comprehensive resident assessment not reviewed and updated at least quarterly as indicated by date and signature of person completing the quarterly review.
5) The assessment process is not coordinated by a registered nurse, as indicated by date and signature on comprehensive assessment.

e) Agency Note
1) Nursing home residents admitted prior to October 1, 1990 are required to have a minimum data set comprehensive assessment completed before October 1, 1991. IOCs which take place between January 1, 1991 and October 1, 1991 which include residents admitted prior to October 1, 1990 who have not yet had a minimum data set comprehensive resident assessment are to be scored "0" with no Need Not Met given.
2) Reassessment must be consistent with observation, interview progress notes and care plan.
3) Interdisciplinary team shall include resident, resident's family and/or legal representative and/or guardian; attending physician; registered nurse; licensed nurse responsible for resident; social service staff; and other appropriate staff in disciplines as determined by the resident's needs; such as, activity staff; dietary staff; direct care certified nurses' aide; and rehabilitation personnel.
4) A "significant change" means any of the following:
A) Deterioration in two or more activities of daily living, communication and/or cognitive abilities that appear permanent. For example, simultaneous functional and cognitive decline often
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experienced by residents with chronic, degenerative illness such as Alzheimer's Disease or pronounced functional changes following a stroke.

B) Loss of ability to freely ambulate or to use hands to grasp small objects to feed or groom oneself such as a spoon, toothbrush or comb. Such losses must be permanent and not attributable to identifiable, reversible causes such as drug toxicity from introducing a new medication or an episode of acute illness such as influenza.

C) Deterioration in behavior, mood and/or relationships where staff concludes that these changes in the resident's psychosocial status are not likely to improve without staff intervention.

D) A serious clinical complication.

E) A new diagnosis of a condition that is likely to affect the resident's physical, mental or psychosocial well-being over a prolonged period in time.

F) Onset of a significant weight loss or weight gain (5% in one month, 7.5% in three months, 10% in six months or a continuous weight loss or gain over six months) which is not a care plan goal.

G) Deterioration in a resident's health status where this change places the resident's life in danger, e.g., stroke, heart condition or diagnosis of metastatic cancer; is associated with a serious clinical complication, e.g., initial onset of nonrelieved delirium, or recurrent loss of consciousness; or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental or psychosocial well-being over a prolonged period of time, e.g., Alzheimer's Disease or diabetes.

H) A marked and sudden improvement in the resident's status; for example, a comatose resident regaining consciousness.

5) Document in progress notes the initial identification of a significant change in status.

6) Once the interdisciplinary team determines the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of this determination.

7) Do not assess the resident if declines in a resident's physical, mental or psychosocial well-being are being attributed to:

A) Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose
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B) Short term acute illness such as a mild fever secondary to a cold from which facility staff expect full recovery of the resident's premorbid functional abilities and health status.

C) Well established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease.

8) The facility may amend assessment information collected during the 14 days postadmission period up until the 21st day after admission if any of the following three circumstances occur:

A) Staff have no way to complete an item by the 14th day because information is not available;

B) Further observation and interaction with the resident reveals the need to alter the initial assessments in any of the following MDS domains: cognitive patterns, communication patterns, potential for self-care improvement/rehabilitation, psychosocial well-being, mood and behavior patterns and activity pursuit patterns; or

C) Upon admission, the resident's condition is unstable because he/she is experiencing an acute illness or flare-up of a chronic problem and the acute illness or chronic problem is controlled by the 21st day.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147. TABLE D Functional Needs and Restorative Care (Repealed)

a) Category I—Bathing/Grooming

1) Functional Area

A) Verification of Level of Service
   i) Kardex, flow sheet or care plan;
   ii) Observation of resident to determine overall functional ability;
   iii) Observation of 5-12 residents during bathing to determine level of assistance provided; and
   iv) Need for hands-on assistance must be supported by assessment/reassessment.

B) Needs Not Met
   i) Following supplies are not available and/or the facility does not have a method of identifying individual resident
supplies. Resident supplies are not stored in a sanitary manner: toothbrush and paste; comb; denture supplies, if appropriate; shavers or razors; washcloth and towels; and soap.

i) Facility does not have available: clippers or scissors for nail care; individualized deodorants; and shampoos.

ii) Equipment is not: in good repair; clean; sanitized between resident use; used, as evidenced by resident's appearance.

iii) Resident has: dirty or untrimmed nails; dirty or uncombed hair; body odor; a dirty body, includes earwax build up, foreign matter crusted on eyes or mouth, etc.; lack of oral hygiene; and not been shaved (see Agency Note).

C) Agency Note

i) Consider the time of day, i.e., right after a meal a resident may not be as clean as early morning.

ii) If the case manager determines the documented level of bathing assistance required by the facility staff is incorrect in more than 25% of the residents checked for verification, the case manager will have to check more residents for verification. (All residents in the facility may have to be checked if the facility does not give accurate information.)

iii) If resident is not shaved due to personal preference, it should be noted in the Kardex or care plan.

iv) Odor related to a medical condition or untreatable cause should not be marked NEED NOT MET, so long as the problem has been identified. The problem is documented in the clinical record and there is an appropriately implemented treatment plan to correct or alleviate the condition.

2) Restorative

A) Verification of Level of Service

i) Restorative assessment completed by an RN, who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.

ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain
measurable goals to increase the resident's functional level utilizing interdisciplinary approaches.

iii) Observation of this program to ensure plan as specified in the care plan is being implemented.

iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

B) Need Not Met

i) No assessment/reassessment in the last 90 days.

ii) Goals met and new goals not established.

iii) Restorative intervention not implemented as specified in the care plan.

iv) Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course), and clinical record and care plan do not indicate staff is addressing the lack of progress.

v) Licensed staffs' notations of the resident's response is not documented at least monthly in the clinical record.

C) Agency Note

i) Clinical record may include any type of interdisciplinary team documentation, i.e., treatment report, flowsheet, etc.

ii) Assessment should address: identification of resident's strengths and potential; identification of resident's deficit areas and causes; and strengths/deficits should be stated in specific terms.

iii) Restorative program should address steps of program reflected in care plan.

iv) Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.

v) If resident fails to increase his/her functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.

vi) Progress should be noted by objective documentation indicating increase in resident's functional level.

vii) Restorative programs must be integrated into the resident's daily care except when contraindicated at which time the program should be revised.

viii) Resident must receive Level 1 or 2 services to qualify for a
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An assessment should be completed identifying the resident's current level of functioning in bathing and grooming. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability or has lost functional ability.

Prior to a resident being given credit for restorative care in any program, the following must be met: an assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course; a reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response; program must be reflected in the resident's care plan; staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly; and the program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

3) Restorative Maintenance
   A) Verification of Level of Service
      i) Restorative assessment completed by an RN, who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist review must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
      ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase/maintain the resident's
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iii) Observation of this program to ensure plan as specified in the care plan is being implemented.

iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

B) Needs Not Met

i) No assessment/reassessment in the last 90 days.

ii) Restorative intervention not implemented as specified in the care plan.

iii) Licensed staffs' notation of the resident's response not documented at least monthly in the clinical record.

iv) Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.

C) Agency Note

A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

b) Category 2—Clothing

1) Functional Level

A) Verification of Level of Service

i) Kardex or flowsheet or care plan.

ii) Observation of resident to determine overall functional ability.

iii) Observation of 5-12 residents during dressing to determine level of assistance provided.

iv) Need for hands-on assistance must be supported by assessment/reassessment.

B) Need Not Met

When resident is:

i) Not wearing clothing that is clean, odor-free, in good repair, well-fitting, appropriate to the season, time of day and condition of the resident.

ii) Not wearing underwear, unless contraindicated.

iii) Not wearing socks, unless contraindicated.

iv) Not wearing shoes or slippers, unless contraindicated.

v) Wearing clothing visibly marked with name.

C) Agency Note
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i) If shoes or slippers are unable to be worn due to physical disability or physician's orders, this must be documented on the Kardex or the care plan.

ii) Consider time of day, i.e. at 4:00 p.m., clothing may not be as clean as at 8:00 a.m.

iii) If underwear is contraindicated this must be documented on the Kardex or the care plan.

2) Restorative
A) Verification of Level of Service
   i) Restorative assessment completed by an RN, who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
   ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase the resident's functional level utilizing interdisciplinary approaches.
   iii) Observation of this program to ensure plan as specified in the care plan is being implemented.
   iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

B) Need Not Met
   i) No assessment/reassessment in the last 90 days.
   ii) Goals met and new goals not established.
   iii) Restorative intervention not implemented as specified in the care plan.
   iv) Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course) and the clinical record and care plan does not indicate staff addressing the lack of progress.
   v) Licensed staffs' notations of the resident's response not documented at least monthly in the clinical record.

C) Agency Note
   i) Clinical record may include any type of interdisciplinary team documentation, i.e., treatment report, flowsheet, etc.
   ii) Assessment should address: identification of resident's
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strengths and potential; identification of resident's deficit areas and causes; and strengths/deficits should be stated in specific terms.

iii) Restorative program should address steps of program reflected in care plan.

iv) Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.

vi) Progress should be noted by objective documentation indicating increase in resident's functional level.

vii) If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.

viii) Resident must receive Level 1 or 2 services to qualify for a corresponding ADL restorative program.

ix) Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program should be revised.

x) An assessment should be completed identifying the resident's current level of functioning in dressing. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability or has lost functional ability.

Prior to a resident being given credit for restorative care in any program, the following must be met: an assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course; a reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response; program must be reflected in the resident's care plan; staff carries out the restorative care programs as indicated by the plan and records resident's
response to the restorative care programs in the clinical record at least monthly; and the program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

3) Restorative Maintenance
   A) Verification of Level of Service
      i) Restorative assessment completed by an RN, who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
      ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase/maintain the resident's functional level utilizing interdisciplinary approaches.
      iii) Observation of this program to ensure plan as specified in the care plan is being implemented.
      iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.
   B) Needs Not Met
      i) No assessment/reassessment in the last 90 days.
      ii) Restorative intervention not implemented as specified in the care plan.
      iii) Licensed staffs' notation of the resident's response not documented at least monthly in the clinical record.
      iv) Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.
   C) Agency Note
      A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of ADL.

e) Category 3—Eating
   4) Functional Area
      A) Verification of Level of Service
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i) Kardex or flowsheet or care plan.

ii) Observation of resident to determine overall functional ability.

iii) Observation of all residents to assure staff is providing assistance as indicated in the Kardex and/or flowsheet and/or care plan.

iv) Physician order for tube feeding.

v) Need for hands-on assistance must be supported by assessment/reassessment.

B) Need Not Met

i) Does not receive the assistance as indicated in the Kardex or flow sheet or care plan or as indicated by observation of the resident.

ii) Does not receive diet as ordered, including snacks as scheduled.

iii) Does not have adaptive devices available, if indicated in the Kardex and/or flowsheet and/or care plan, i.e. plate guards, built-up spoons and forks and clothing protectors. Adaptive devices are not used appropriately as indicated in the clinical record.

iv) Fluids not offered and/or accessible to residents between meals.

v) Food not served at appropriate temperature; i.e. warm foods not served warm and cold foods are not served cold as evidenced by resident’s response/verbalization and as confirmed by case manager observation.

vi) Food appropriate utensils not provided/available.

vii) Facility protocol for weighing residents not followed.

viii) Facility not following its own protocol and/or written procedures for tube feedings.

ix) Weight loss or gain of 5% in one month, 7.5% in three months, 10% in six months or a continuous weight loss or gain over six months not reported to the physician.

x) Plan for corrective action regarding weight loss or gain not developed or implemented, as per physician order.

xi) Protocols not available or followed for tube feeding.

xii) Tube feeding not rendered by licensed personnel.

xiii) Equipment for tube feedings is soiled or improperly maintained.

C) Agency Note
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Protocol must address safety, infection control procedures, I & O, frequency of weighing and should outline steps of tube feeding procedures. If protocol is in question, refer to team Physician Consultant.

2) Restorative
   A) Verification of Level of Service
      i) Restorative assessment completed by an RN who has completed an approved rehabilitation course, a registered occupational therapist, a registered physical therapist or a speech language pathologist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
      ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase the resident's functional level utilizing interdisciplinary approaches.
      iii) Observation of this program to ensure plan as specified in the care plan is being implemented.
      iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.
   B) Need Not Met
      i) No assessment/reassessment in the last 90 days.
      ii) Goals met and new goals not established.
      iii) Restorative intervention not implemented as specified in the care plan.
      iv) Resident not meeting goal(s) (established by the physical therapist, occupational therapist, speech language pathologist, or registered nurse who has successfully completed an approved rehabilitation course) and the clinical record, and care plan does not indicate staff is addressing the lack of progress.
      v) Licensed staff's notations of the resident's response not documented at least monthly in the clinical record.
   C) Agency Note
      i) Clinical record may include any type of interdisciplinary team documentation, i.e., treatment report, flowsheet, etc.
      ii) Assessment must address: identification of resident's strengths and potential; identification of resident's deficit areas and causes; and strengths/deficits must be stated in
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specific terms.

iii) Restorative program must address steps of program—reflected in care plan.

iv) Restorative programs are limited to residents who cannot perform functional tasks, but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.

v) If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.

vi) Progress by objective documentation indicating increase in resident's functional level.

vii) Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program must be revised.

viii) Resident must receive Level 1 or 2 services to qualify for a corresponding ADL restorative program.

ix) An assessment should be completed identifying the resident's current level of functioning in eating. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability or has lost functional ability.

x) Prior to a resident being given credit for restorative care in any program, the following must be met: an assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, a registered nurse who has successfully completed an approved rehabilitation course, or a speech language pathologist; a reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response; program must be reflected in the resident's care plan; staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly; and the
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program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his/her functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

3) Restorative Maintenance
   A) Verification of Level of Service
      i) Restorative assessment completed by an RN who has completed an approved rehabilitation course, a registered occupational therapist, a registered physical therapist or a speech language pathologist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.
      ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase/maintain the resident's functional level utilizing interdisciplinary approaches.
      iii) Observation of this program to ensure plan as specified in the care plan is being implemented.
      iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.
   B) Needs Not Met
      i) No assessment/reassessment in the last 90 days.
      ii) Restorative intervention not implemented as specified in the care plan.
      iii) Licensed staff's notation of the resident's response not documented at least monthly in the clinical record.
      iv) Resident not meeting maintenance goal(s) established by the physical therapist, occupational therapist, speech language pathologist, or registered nurse who has successfully completed an approved rehabilitation course.
   C) Agency Note
      A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of ADL.

   d) Category 4—Mobility
      1) Functional Area
         A) Verification of Level of Service
            i) Kardex or flowsheet or care plan.
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ii) Observation of residents to determine overall functional ability and if wheelchair, walkers, or other assistive devices are available and used.

iii) Residents should be observed being assisted by facility staff, as needed.

iv) Need for hands-on assistance must be supported by assessment/reassessment.

B) Need-Not-Met

i) Resident who is not able to change position independently has not been exercised or ambulated and repositioned every two hours.

ii) Resident is not positioned properly.

iii) Assistive device is not in proper working order, and/or clean or well-fitting, i.e. walker, cane, wheelchair, etc.

iv) The facility does not have, or is not implementing, a plan for monitoring a resident who is unable to use the call bell or the call bell is not within reach of a resident in his or her room who can use the call bell.

v) Resident needs and does not have assistive device as ordered by a physician.

vi) Staff do not respond when summoned by a resident for help or assistance.

vii) Not following physician order on bed rest.

C) Agency Note

i) Residents who are totally bed fast will be scored Level 0 for mobility.

ii) If resident is unable to use call bell, care plan or Kardex must indicate staff plan for monitoring resident.

iii) Bed rest is an order by physician that resident is to be in bed at all times, except up at intervals of no more than one hour up to three times a day, i.e. for meals in room. Scoring will be according to the assistance required and provided.

2) Restorative

A) Verification of Level of Service

i) Restorative assessment completed by an RN, who has completed an approved rehabilitation course, a registered occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly
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changes to warrant a comprehensive assessment or review sooner.

ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase the resident's functional level utilizing interdisciplinary approaches.

iii) Observation of this program to ensure plan as specified in the care plan is being implemented.

iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

B) Need Not Met

i) No assessment/reassessment in the last 90 days.

ii) Goals met and new goals not established.

iii) Restorative intervention not implemented as specified in the care plan.

iv) Resident not meeting goal(s) (established by the physical therapist, occupational therapist or registered nurse who has successfully completed an approved rehabilitation course) the clinical record, and care plan does not indicate staff is addressing the lack of progress.

v) Licensed staff's notations of the resident's response is not documented at least monthly in the clinical record.

C) Agency Note

i) Clinical record may include any type of interdisciplinary team documentation, i.e., treatment report, flowsheet, etc.

ii) Assessment should address: identification of resident's strengths and potential; identification of resident's deficit areas and causes; and strengths/deficits should be stated in specific terms.

iii) Restorative program should address steps of program reflected in care plan.

iv) Restorative programs are limited to residents who cannot perform functional tasks; but an assessment has determined that the resident has a reasonable likelihood of increasing his/her functional level.

v) If resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be carried out in Level 2 Maintenance.

vi) Progress by objective documentation indicating increase in
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vii) Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time they should be revised.

viii) Resident independent in mobility due to assistive device may qualify for ADL restorative mobility program and PT when program is to assist resident to move to a less restrictive mode of ambulation, otherwise an ADL must be scored a 1 or higher.

ix) An assessment should be completed identifying the resident's current level of functioning in bed mobility, transfer and locomotion. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability or has lost functional ability.

x) Prior to a resident being given credit for restorative care in any program, the following must be met: an assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist, or a registered nurse who has successfully completed an approved rehabilitation course; a reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response; program must be reflected in the resident's care plan; staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly; and the program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

3) Restorative Maintenance

   A) Verification of Level of Service

   i) Restorative assessment completed by an RN who has completed an approved rehabilitation course, a registered
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occupational therapist or a registered physical therapist must be done annually with reviews done quarterly unless the resident's physical and/or mental status significantly changes to warrant a comprehensive assessment or review sooner.

ii) Restorative assessment/reassessment, at least every 90 days, with program noted on care plan and must contain measurable goals to increase/maintain the resident's functional level utilizing interdisciplinary approaches.

iii) Observation of this program to ensure plan as specified in the care plan is being implemented.

iv) Monthly documentation of resident response by licensed staff or cosigned by licensed staff.

B) Needs Not Met

i) No assessment/reassessment in the last 90 days.

ii) Restorative intervention not being implemented as specified in the care plan.

iii) Resident is not meeting maintenance goal(s) established by the physical therapist, occupational therapist, or registered nurse who has successfully completed an approved rehabilitation course.

iv) Licensed nurses' notation of the resident's response is not documented at least monthly in the clinical record.

C) Agency Note

A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

e) Category 5—Continence

1) Functional Area

A) Verification of Level of Service

i) Assessment and care plan or assessment and Kardex.

ii) Observation of resident to determine overall functional ability.

iii) Staff should be observed toileting the resident as per resident assessment (Level 2 only).

iv) Staff's mechanism to identify resident's need to toilet (Level 2 only).

v) Need for hands-on assistance must be supported by assessment/reassessment.
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B) Need-Not-Met
   i) Facility not following its own protocol for a bowel and bladder program.
   ii) Resident is allowed to remain wet and/or soiled for prolonged periods of time as demonstrated by skin irritation, dried urine and/or feces stains in bed linen and/or clothing.
   iii) Resident is not thoroughly cleaned after episode of incontinence as demonstrated by smell of urine/defecation on body and clothing.
   iv) Resident found wet and/or soiled and remains wet and/or soiled thirty minutes after finding.
   v) Staff is not immediately responsive to resident's request for toileting.

C) Agency Note
   i) For the purpose of this item, Level 2 includes informal B & B programs. Level 2 scores include residents who dribble and are assisted to the bathroom.
   ii) If unable to verify level of service through observation of residents being toileted, target 5-12 residents to determine if bed and/or clothing is wet, soiled or if odor of urine or feces is present.
   iii) Assessment as indicated means focusing on the portion of the previously completed overall resident assessment which indicates the resident's bowel and bladder capabilities. The assessment reflects the current needs of the resident.
   iv) Give zero score for resident who dribbles and changes own continence pads.

2) Restorative
   A) Verification of Level of Service
      i) Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase the resident's functional level utilizing interdisciplinary approaches.
      ii) Observation of the program to ensure that plan is being implemented as specified in the care plan and is individualized to the resident's needs.
      iii) Monthly documentation of resident response by Licensed staff or co-signed by licensed staff.

B) Need-Not-Met
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i) No assessment/reassessment within 90 days.

ii) Goal met and new goal not established.

iii) Restorative intervention not implemented as specified in care plan.

iv) Resident not meeting goal(s) established by the interdisciplinary team and the clinical record and care plan does not indicate staff is addressing the lack of progress.

v) Staff notations of the resident response to the program is not documented at least monthly in the clinical record.

vi) Not following facility protocol.

vii) Has not established facility protocol.

C) Agency Note

i) Clinical record may include any type of interdisciplinary team documentation, i.e., treatment report, flowsheet, etc.

ii) Assessment addresses identification of resident's deficit areas and causes such as medications, mental status, ability to control urine, self-care abilities, mobility, voiding/elimination patterns/hydration baseline, history of urinary tract infection and the strengths and deficits should be stated in specific terms.

iii) Facility protocol should include types of incontinence, assessment, plan, implementation measures, evaluation techniques, staff training and monitoring.

iv) Restorative program and approaches should be reflected in the care plan.

v) Restorative programs are limited to residents whose assessment has determined that there is a reasonable likelihood of increasing his or her functional level.

vi) If resident, after initial improvement, fails to continue to increase his/her functional ability, credit will still be given as long as restorative program continues to be carried out (Level 2-Maintenance).

vii) Progress should be noted by objective documentation indicating increase in resident's functional level as compared to initial baseline and/or most recent assessment.

viii) Restorative programs must be integrated into the resident's daily care except when contraindicated, at which time the program should be revised.

ix) Resident must be scored a Level 2 (in functional area) in order to qualify for a corresponding ADL Restorative
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Continence program:

x) The formal program must include, but is not limited to, training/counseling, voiding and elimination pattern records, toileting and hydration.

xi) The training program does not have to be hands-on assistance.

xii) Give zero score for formal bowel and bladder program if facility is not following its own protocol.

xiii) An assessment should be completed identifying the resident's current level of functioning in continence. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed in ability or has lost functional ability.

xiv) Prior to a resident being given credit for restorative care in any program, the following must be met: an assessment completed identifying the resident's current level of functioning and plan developed to increase this level of functioning by either a physical therapist, occupational therapist or a registered nurse who has successfully completed an approved rehabilitation course; a reassessment is conducted as indicated in the initial plan. An assessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response; program must be reflected in the resident's care plan; staff carries out the restorative care programs as indicated by the plan and records resident's response to the restorative care programs in the clinical record at least monthly; and the program is reviewed at the time of the care plan meeting by the interdisciplinary team; if resident fails to increase his functional ability, after initial improvement, credit will still be given as long as restorative care continues to be provided.

3) Restorative Maintenance

A) Verification of Level of Service

i) Restorative assessment/reassessment at least every 90 days with program noted on care plan and must contain measurable goals to increase/maintain the resident's
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functional level utilizing interdisciplinary approaches.

ii) Observation of this program to ensure plan as specified in the care plan is being implemented.

iii) Monthly documentation of resident response by licensed staff or co-signed by licensed staff.

B) Needs Not Met

i) No assessment/reassessment in the last 90 days.

ii) Restorative intervention not implemented as specified in the care plan.

iii) Staff notation of the resident's response to the program not documented at least monthly in the clinical record.

iv) Resident not meeting maintenance goal(s) established byconst

v) Not following facility protocol.

vi) A facility cannot place a resident on maintenance for whom the facility has not tried and documented a variety of restorative measures which increased the resident's functional level of this ADL.

f) Category 6—Psychosocial/Mental Status

1) Verification of Level of Service

A) Observation of actual intervention, i.e., if group, observe group; if 1:1 counseling, observe session; if episodic intervention, observe if possible.

B) Completed assessment identifying resident's current psychosocial needs.

C) Staff assessing and implementing programs must be knowledgeable of the individual resident's current program.

D) Care plan with specific intervention to address identified resident's needs with measurable objectives.

E) Resident's response to care plan is documented in the clinical record monthly by staff responsible for the program.

F) QHP is monitoring psychosocial program as evidenced by signing off on the assessment and response notes, with written recommendations as appropriate in the clinical record.

G) Attendance sheets for scheduled 1:1 and group sessions.

H) Program plan for scheduled 1:1 and group sessions.

I) Episodic intervention and response to intervention is documented in the clinical record every other week.

2) Need-Not-Met
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A) Resident is not meeting goal(s) established by QHP or staff responsible for the program. Progress notes or care plan does not indicate staff is addressing the lack of progress.

B) Care plan is not adhered to. The resident attended less than 85% of these sessions in the last three months and the clinical record does not indicate resident absence was due to illness or absence from the facility.

C) Groups are larger than eight.

D) Group programs or 1:1 have no program plan.

E) Groups or 1:1 counseling meet less than three times a week.

F) Documentation of resident's response to intervention is not in the clinical record every month for 1:1 and groups by staff monitoring the program.

G) QHP is not monitoring psychosocial program as evidenced by absence of signing off on assessment and response notes and there are no written recommendations, as appropriate in the clinical record.

H) Episodic intervention and resident response to the intervention is not documented every other week in the clinical record.

I) The assessment for episodic behavior does not include the duration, intensity and frequency of behavior or the precipitating factors and consequences.

3) Agency Note

A) Prior to a resident program being given credit for psychosocial/mental status, the following must be met: An assessment must be completed identifying the resident's current psychosocial status. The assessment should state what the resident is able to do independently and what assistance is required and what makes it necessary. A definite base must be established so that anyone reading the assessment and progress notes can tell whether the individual has progressed or regressed. For episodic intervention, an assessment must include duration, intensity and frequency of behavior. The assessment for episodic behavior must also include precipitating factors and consequences. A reassessment is conducted as indicated in the initial plan. A reassessment must be conducted at least every 90 days but can be conducted as frequently as needed based on outcome and response. A program must be reflected in the resident’s care plan. Staff carries out the program as indicated by the plan and records such in the clinical record at least monthly. The program is reviewed at the
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time of the care plan meeting by the interdisciplinary team.

B) Psychosocial assessments and program plans must be completed by staff and signed off on by a QHP who has a working knowledge of the current psychosocial programs being implemented with the individual resident.

C) Interview questions to the staff assessing and implementing programs would include, but are not limited to, the following:
   i) What program(s) is the resident on?
   ii) Why is the resident in the program?
   iii) What is the resident’s goal(s)?
   iv) What is your responsibility in implementing this program (interventions)?
   v) What is the resident’s response to the intervention?
   vi) If the goal is not achieved, what modifications have been made?

D) If counseling occurs in groups, individuals must have similar problems and goals.

E) Progress should be noted by objective documentation indicating an increase in functional capability and/or decrease in maladaptive behavior. These measurable objectives and goals should be clearly indicated on the resident’s care plan.

F) Programs consisting solely of episodic intervention should be reserved for resident with severe behavior problems that preclude participation in more structured programs.

G) The care plan must be interdisciplinary with approaches as appropriate to the individual resident’s need.

  g) Category 7—Communication
     1) Functional Area
        A) Verification of Level of Service
           i) Assessment.
           ii) Monthly response documented and cosigned by qualified health professional.
           iii) Interventions developed and implemented by the interdisciplinary team.
           iv) Interdisciplinary care plan interventions.
           v) Observation of interventions performed.
        B) Need Not Met
           i) Staff not carrying out interventions as defined in interdisciplinary care plan.
           ii) Clinical record does not indicate resident response to
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intervention monthly by qualified health professional
cosignature.

C) Agency Note
 i) Approved appliances and assistive devices, including
 application and care of the appliance, are covered in the
 appliance category.
 ii) Interventions must have a comprehensive, seven days a
 week philosophy and must be implemented at each
 opportunity on a daily basis.
 iii) Interventions must be monitored by interdisciplinary team.
 iv) Staff should receive inservice training, as required.
 v) Interventions must be conducted on an individual resident
 basis.

2) Speech Therapy
 A) Verification of Level of Service
  i) Observation of treatment and monthly therapist review
 documentation. This review documentation must indicate
 progress.
  ii) Assessment.
  iii) Speech Pathologist's or Audiologist's treatment notes.
  iv) Monthly reevaluation by the certified speech-language
 pathologist/audiologist.
  v) Physician Order
 B) Need Not Met
  i) Plan is not implemented as specified by the therapist.
  ii) Goals are not designed to increase resident's functional
 capabilities.
  iii) Resident is not meeting goal(s) and clinical record does not
 indicate staff is addressing lack of progress.

C) Agency Note
 i) Speech-language Pathology and Audiology Rehabilitative
 Program shall be planned and designed specifically for the
 resident by a certified speech-language
 pathologist/audiologist or Clinical Fellow.
 ii) Progress must be noted by standard speech
 therapist/audiologist objective measures.
 iii) Measurable goals must be designed to increase resident's
 functional means of communication and/or ability to
 swallow.
 iv) Treatment sessions should be one-on-one; however, groups
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of two are acceptable if residents’ goals and functional levels are similar.

\( \triangleright \) Refer to 147/Table K for Speech Language Pathology/Audiology Rehabilitative Services Measurement of Progress.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE E Service (Repealed)

a) Category 1—Appliances

1) Verification of Level of Service
A) Physician order
B) Care plan or Kardex
C) Documentation must include:
   i) Type of appliance;
   ii) When to apply; and
   iii) Care/maintenance.
D) Observation of resident wearing appliance and indication that staff assists either with application and/or cleaning or maintenance.

2) Need Not Met
A) Physician has ordered appliance and facility has not complied with physician order.
B) Appliance is not in use as indicated by observation.
C) Appliance does not fit properly.
D) Appliance is dirty.
E) Appliance is nonfunctional and clinical record does not indicate date of dysfunction or plans for correction.

3) Agency Note
No physician order necessary for appliances resident has on admission, i.e., eyeglasses, dentures.

b) Category 2—Catheterization

1) Verification of Level of Service
A) Physician order
B) Care plan or flowsheet or Kardex.
C) Observation of resident noting type of catheter.
D) Documentation must include:
   i) Type of catheter;
   ii) Care and maintenance;
   iii) Frequency of intermittent catheterization; and
   iv) Output for indwelling catheter.
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2) Need-Not-Met
   A) Facility does not have protocols for catheterization and catheter care.
   B) Facility not following its own protocol or physician order for catheterization, catheter care or I & O.
   C) Signs of inflammation at insertion site or penile irritation from Texas catheter without clinical record reflecting date of
   D) Tubing and/or bag improperly positioned and/or maintained.
   E) Urine sedimentation or urine not clear and clinical record does not indicate observation and subsequent plan of action.
   F) Catheterization rendered by nonlicensed personnel.

3) Agency Note
   A) Protocol must address when intake or output is required.
   B) Protocol must address infection control.
   C) Intermittent catheterization means daily catheterization.
   D) Urine sedimentation would include blood, mucus and/or other matter.
   E) Leg bags can be applied by CNA trained in process when allowed by facility protocol.
   F) Facility protocol should address:
      i) Ongoing inservice education of direct care staff; and
      ii) Ongoing monitoring of technique of direct care staff.

Category 3—Pressure Ulcer Treatment

1) Verification of Level of Service
   A) Physician’s order
   B) Care plan or Treatment Plan
   C) Observation of pressure ulcer

2) Need-Not-Met
   A) Resident has a pressure ulcer and the facility is not addressing with treatment or preventative program.
   B) Clinical record does not reflect current wound status.
   C) Specific treatment plan not being followed.
   D) Treatment not implemented by licensed personnel.
   E) Facility does not have or follow protocol for pressure ulcer management including notification of physician when pressure ulcer develops or when change in pressure ulcer occurs.
   Management program must include a resident assessment which addresses the following points:
      i) Turning and positioning;
      ii) Nutritional support;
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iii) Nutritional assessment;
iv) ROM;
v) Supportive devices; and
vi) Infection control.

3) Agency Note
A) Staging of pressure ulcers:
i) Stage I—A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
ii) Stage II—A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.
iii) Stage III—A full thickness of skin is lost, exposing the subcutaneous tissues presents as a deep crater with or without undermining adjacent tissue.
iv) Stage IV—A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.

B) A Stage I pressure ulcer can be suspected if a reddened area does not disappear 30 minutes after pressure is relieved.

C) The skin of a Stage II ulcer may appear bluish or dusky in color.

D) Conditions that may be confused with pressure ulcers:—stasis ulcers; vasculitic ulcers; amputation stump breakdown; other open skin lesions such as basal cell carcinomas, burns, etc.; skin rashes, including diaper rash; and fungal infections.

E) Score PROM, if it is being carried out according to the guidelines under PROM.

F) Admission or risk assessment must indicate where pressure ulcer developed.

d) Category 4—Pressure Ulcer Prevention
1) Verification of Level of Service
A) Assessment to indicate level of risk and reassessment per preventative plan.
B) Preventative plan is in care plan.
C) Observation of the resident to verify that the preventative plan is being carried out.

2) Need Not Met
A) Individualized pressure ulcer preventative plan is not in care plan.
B) Skin is not intact or signs of breakdown are present and the clinical record does not indicate observation and subsequent change of treatment plan.
C) Preventative treatment plan not implemented.
NOTICE OF ADOPTED AMENDMENTS

D) Facility is not following pressure ulcer preventative policy and procedures.
E) Frequency of reassessments must be at least every 90 days, or more frequently if condition changes.

3) Agency Note
A) Preventative plan must address:
   i) Frequency of observations of skin condition and documentation in the clinical record; and
   ii) Which type of staff should provide this care.
B) Assessment instruments must be standardized and must differentiate between moderate and high risk.
C) Score PROM if it is being carried out according to the guidelines under PROM.
D) If an individualized preventative plan is in question, refer to team physician.

e) Category 5—Wound Care
1) Verification of Level of Service
   A) Physician's order
   B) Treatment plan, care plan, Kardex or treatment sheet.
   C) Observation of wound and treatment being given.
2) Need-Not-Met
   A) Treatment not implemented using aseptic technique or as indicated in physician's order.
   B) Care not performed by licensed personnel.
   C) Wound present with no indication facility staff is aware of wound.
   D) Clinical record does not reflect current status of the wound.
   E) Physician is not notified of wound or change in wound status.
   F) Frequency of the documentation and observation of the wound status is not addressed in the individual treatment plan.
   G) No facility policy and procedure for wound care, including infection control.
   H) Infection control procedures not followed as per facility policy.
3) Agency Note
   A) Wound care (treatment of skin lesion, other than a pressure ulcer) may include wet packs, soaks, whirlpools for open lesions, or ointments when ordered by a physician and applied to lesions.
   B) "Friction burns" or abrasions resulting from repetitive friction are included in this category as are stasis ulcers, rashes, skin tears.
   C) Frequency of the documentation and observation of the wound status must be addressed in treatment plan until the wound is
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f) Category 6—Injections

1) Verification of Level of Service
   A) Physician order
   B) Nurse's signature or initials must follow documentation of administration of injection.

2) Need-Not-Met
   A) Facility not following physician order.
   B) Injection site not documented or injection not documented as given.
   C) Injection site not free of signs of inflammation/irritation and the clinical record does not reflect this observation and there is no subsequent plan of action.
   D) Injection site not rotated according to facility protocol or facility has no protocol for rotation of injection sites.

3) Agency Note
   A) Yearly injections not included, i.e., flu shots, mantoux, etc.
   B) Credit is given for all other injections if the service is received within the last six months.

g) Category 7—Intravenous Therapy: I.V.s and Clysos

1) Verification of Level of Service
   A) Physician's order
   B) Nurse's signature or initials on medication or treatment record.

2) Need-Not-Met
   A) Insertion site not free of inflammation and the clinical record does not reflect this observation and a subsequent plan of care.
   B) I.V. tubing and dressing changes not done in accordance with facility's protocol.
   C) Facility does not have protocols for I.V.s or clysis.
   D) Facility does not follow its own protocol on I.V.s or clysis.
   E) I.V. fluids or medications not documented as given per physician orders.
   F) Intake and output not recorded and monitored while on I.V. therapy.

3) Agency Note
   A) If I.V. is for hydration purposes, the clinical record should include documentation as to p.o. hydration attempts and resident's poor response.
   B) Credit is to be given for I.V.s or clysis if the service was received within the last six months.
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C) Hickman Catheter, Groshong Catheter and heparin locks are included in this category.

h) Category 8—Laboratory Specimen Service

1) Verification of Level of Service
   A) Physician order.
   B) Documentation that specimen was obtained by staff.
   C) Lab results conveyed to physician according to facility protocol.

2) Need-Not-Met
   A) Specimen not collected at specified times.
   B) Facility has no lab protocol.
   C) Staff does not adhere to facility’s protocol for subsequent actions following receipt of laboratory report.
   D) Physician orders lab and facility does not complete.
   E) Site from which specimen is drawn not rotated according to facility protocol or facility has no protocol for rotation of sites.

3) Agency Note
   A) Protocol should address:
      i) Level of staff who will collect each type of specimen;
      ii) How specimens should be stored prior to testing;
      iii) How licensed staff is informed of results of lab specimens collected by unlicensed staff; and
      iv) How licensed staff document action taken with specimen results.
   B) Routine voided specimens are scored here.
   C) A physician referral should be made when a case manager questions whether lab work is necessary.

i) Category 9—Medications/Medication Monitoring

1) Verification of Level of Service
   A) Physician order
   B) Nurse's signature or initials on the medication record following administration of medicine.
   C) Monthly documentation of pharmacist's review.
   D) Assessment/reassessment at least every 90 days with program noted on care plan (Level 2 only).
   E) Monthly documentation of resident response to self-medication program or psychotropic drug program by licensed nursing staff (Level 2 only).

2) Need-Not-Met
   A) Facility does not have a protocol for self-medication or psychotropic drug management.
NOTICE OF ADOPTED AMENDMENTS

B) Facility has not established medication protocol.
C) Facility does not follow medication protocol as established.
D) PRN medication given and reason for administration and response is not documented.
E) Clinical record does not indicate resident's allergy, if applicable.
F) Resident not given adequate hydration following ingestion of medications unless medications given with solids.
G) Medication not documented as given and no documentation of reason medication was withheld.
H) Medication not given within one (1) hour of scheduled time.
I) Medication monitoring is not consistent.
J) Medicated patches and topical medications are not rotated.
K) On comprehensive assessment, the resident indicated a preference for self-medication (documented in clinical record) but the staff did not place the resident in a program for self-medication or self-medication training and the clinical record does not reflect the interdisciplinary team's reason for denial of self-medication (Level 2 only).
L) Resident is self-medicating or on a training program for self-medication. Clinical record does not reflect monthly documentation of resident response to program; OR medication is not stored properly; OR medications are not documented as self-administered on medication administration record (Level 2 only).
M) Not following program plan as indicated on care plan (Level 2 only).
N) Not following protocol for self-medication administration (Level 2 only).
O) Not following protocol for psychotropic management program (Level 2 only).
P) No monthly note by licensed nurse for self-medication or psychotropic drug management program (Level 2 only).

3) Agency Notes
A) While there is no specific time limit on the duration of med monitoring, there must be evidence that the resident has not stabilized.
B) Medications are scored the day of the survey unless a routine pattern has been established, i.e., every three days or every other day.
C) Monitoring for injections is covered under the injections category.
D) If the case manager wants verification from team physician as to
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whether special monitoring is necessary, mark physician referral.

E) Example of "off hours or by multiple routes":
   i) Oral medication given at 10 a.m., 3 p.m., 7 p.m., and 11 p.m.;
   ii) Eye drops administered in left eye in the morning, in addition to oral medications; and
   iii) Application of topical medications, i.e., nitro pads, nitro paste, estrogen patches, etc., or the use of an oral inhaler, i.e., Provental, Alupent, Aerobid, etc.

F) If resident is now free of psychotropic drugs as a result of the drug reduction program, he/she may continue to be scored a Level 2. The monthly progress note should address symptoms/alternate behavior interventions as well as resident response to the program.

G) Credit should be given on Level 2 for self-medication when the program includes teaching the steps which lead to increased resident independent with regard to medications, i.e., the resident knowing the times of different medications, identifying the correct medication by sight and by purpose or name, knowing side effects to report to the doctor or nurse, physically taking the medication, etc.

H) Psychotropic medications shall not be administered for purposes of discipline or staff convenience and when not required to treat the resident's medical symptoms.

I) To qualify for a psychotropic drug program (Level 2), at least the following elements must be in place:
   i) Annual assessment with quarterly assessment reviews to reexamine need for dosage and type of medications to be given.
   ii) Care plan goals/approaches which include behavioral programming and/or dose reduction. Behavioral programming means modification of the resident's behavior and/or the resident's environment, including staff approaches to care, to the largest degree possible to accommodate the resident's behavioral disturbances.
   iii) Quarterly care plan review to determine if modifications are necessary.
   iv) Monthly review by pharmacist to look at resident response to the medications to detect problems, i.e., excessive PRN usage, demonstration of side effects, nontherapeutic blood levels, etc., and report such to DON and/or physician.
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v) Ongoing observation and at least monthly documentation of resident reaction to medication(s) including possible side effects or other problems by licensed nursing staff.

J) Not all psychotropic medications are appropriate for dose reduction or behavioral programming and, therefore, would not qualify for scoring under Level 2.

K) A plan for increased independence in self-medication must be developed on all medications a resident receives; however, a resident does not have to demonstrate successful self-medicating progress for all medications prescribed in order to receive credit for Level 2.

L) Credit for Level 2 self-medication is also given for any resident who has successfully learned to self-medicate (with nurse monitoring) or who has successfully learned steps toward increased independence in the area of medication and is maintained at that level. Resident continues to be assessed for increased independence and a monthly documentation indicates the resident response. Eye drops, antacids, etc., can be included under self-medication if prescribed by a physician and not given on PRN basis.

M) Resident may receive credit on both Level 2 medication and for psychosocial programming.

N) The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of pharmacy services in the facility.

O) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist who must report any irregularities to the attending physician and the director of nursing and these reports must be acted upon.

P) Facility protocol for psychotropic drug programs should include, but is not limited to, graduated dose reduction and behavioral programming, unless clinically contraindicated, in an effort to discontinue these drugs.

Q) Commonly prescribed psychotropic drugs:

Table A. Antipsychotic (Neuroleptic) Drugs

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Promazine</th>
<th>Sparine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trifluromazine</td>
<td>Vesprin</td>
</tr>
<tr>
<td>Thoridazine</td>
<td>Mellaril</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>Serentil</td>
</tr>
<tr>
<td>Acetophenazine</td>
<td>Tindal</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>Trilafon</td>
</tr>
<tr>
<td>Loxapine</td>
<td>Loxitane</td>
</tr>
<tr>
<td>Molindone</td>
<td>Moban</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
</tr>
<tr>
<td>Thiothixene</td>
<td>Navane</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>Prolixin, Permitil</td>
</tr>
<tr>
<td>Fluphenazine Deconate</td>
<td>Prolixin Deconate</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Haldol</td>
</tr>
<tr>
<td>Haloperidol Deconate</td>
<td>Haldol-Deconate</td>
</tr>
<tr>
<td>Droperidol</td>
<td>Inapsine</td>
</tr>
<tr>
<td>Chlorprothixene</td>
<td>Taractan</td>
</tr>
<tr>
<td>Pimozide</td>
<td>Orap</td>
</tr>
</tbody>
</table>

Table B. Antidepressant Drugs

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYCLIC ANTIDEPRESSANT</td>
<td></td>
</tr>
<tr>
<td>Imipramine</td>
<td>Tofranil</td>
</tr>
<tr>
<td>Desipramine</td>
<td>Norpramin</td>
</tr>
<tr>
<td>Doxepin</td>
<td>Adapin, Sinequan</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Elavil, Triavil</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Aventyl, Pamelor</td>
</tr>
<tr>
<td>Amoxapine*</td>
<td>Ascendin</td>
</tr>
<tr>
<td>Maprotiline</td>
<td>Ludiomil</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prozac</td>
</tr>
</tbody>
</table>

TRIAZOLOPYRIDINE ANTIDEPRESSANT

| Trazodone                   | Desyrel   |

MAO INHIBITORS +

| Phenelzine                  | Nardil     |
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Tranylcypromine
   Parnate

PHENYLAMINOKETONE

Bupropion
   Wellbutrin

* Also a neuroleptic drug with all the neuroleptic-side effects.
+ Special diet required; many drug interactions.

Table C. Antianxiety and Hypnotic Drugs

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxazepam</td>
<td>Serax</td>
</tr>
<tr>
<td>Lorazepan</td>
<td>Ativan</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
</tr>
<tr>
<td>Chlorodiazepoxide</td>
<td>Librium</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium</td>
</tr>
<tr>
<td>Chlorazepate</td>
<td>Tranxene</td>
</tr>
<tr>
<td>Flurazepam</td>
<td>Dalmane</td>
</tr>
</tbody>
</table>

BARBITURATES

ANTIHISTAMINES

Hydroxyzine          | Vistaril   |

OTHER

Buspirone            | Buspar     |

Table D. Antimanie

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium Carbonate</td>
<td>Eskalith</td>
</tr>
<tr>
<td></td>
<td>Lithonate</td>
</tr>
<tr>
<td></td>
<td>Lithane</td>
</tr>
</tbody>
</table>
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Serum lithium determinations recommended once or twice weekly during treatment of acute manic episode until serum concentrations and patient's clinical condition have stabilized; recommended at least 2 to 3 months during remission when patient is stabilized.

Table E. Antipsychotics should not be used if one or more of the following is/are the only indication(s):

- Wandering
- Simple pacing
- Crying out, yelling or screaming if such behaviors do not cause an impairment in functional capacity or if they are not quantitatively documented by the facility
- Poor self-care
- Restlessness
- Impaired memory
- Anxiety
- Depression
- Insomnia
- Unseociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness
- PRN use greater than 5 doses in a seven day period without a review of the resident's condition by a physician
- Unspecified agitation

R) Psychotropic drugs refer to drugs which are used for antipsychotic, antidepressant, antimanic, sedative-hypnotic and/or antianxiety purposes and which are intended to control mood, mental status or behavior of the resident.

j) Category 10—Occupational Therapy and Related Rehabilitative Services
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1) Verification of Level of Service
   A) Physician order
   B) Assessment and program planned by the OTR/L.
   C) Observation of rehabilitation aide conducting therapy sessions (Level 1 only).
   D) Monthly review of progress documented by the OTR/L or, if written by the rehabilitation aide, reviewed and co-signed by the OTR/L.
   E) Assessment every 90 days.
   F) Corresponding ADL or psychosocial (for MI diagnosis) program has been developed and implemented (Level 1 only).
   G) Observation of COTA/L conducting therapy sessions (Level 2 only). Observation of OTR/L conducting therapy sessions (Level 3 only).

2) Need Not Met
   A) Plan is not implemented as specified by the therapist.
   B) Goals are not designed to increase resident's functional capabilities.
   C) Resident is not meeting goal(s) and clinical record does not indicate staff is addressing lack of progress.
   D) Resident attended less than 85% of the scheduled sessions in the last three months or since the service began, if less than three months, and clinical record does not indicate resident absenteeism was due to illness or absence from the facility (Level 1 only).
   E) Rehab aide is not a CNA or equivalent. Rehab aide has not received specified training, or has not been enrolled in a rehabilitation course as outlined and approved by IDPA within 90 days of the beginning date of employment in the rehab aide position (Level 1 only).

3) Agency Note
   A) Reimbursement for this item includes assessment done by OTR/L.
   B) The nurse case manager must verify the accuracy of the rehabilitation records by checking the clinical records of at least 25% of the residents in therapy, verifying services were delivered (Level 1 only).
   C) If progress was not made within two months and goals or interventions were not changed, do not score.
   D) Progress should be noted by standard acceptable OTR/L objective measures.
   E) Staffing ratios for rehabilitation 1:30 (per total enrollment) 98
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minutes (Level 1 only). Staffing ratios for therapies for OT Level 2 and Level 3 — 1:1.5 (per 98 minutes).

F) Rehabilitation groups are limited to four residents with similar goals and levels of functioning (Level 1 only).

G) Prior to a resident being given credit in occupational rehabilitative services, the following must be met (Level 1 only):

i) A corresponding ADL restorative program must be developed to increase the resident's functional ability and it must be carried out by the nursing department. The resident's response to the intervention must be recorded in the clinical record.

ii) The occupational rehabilitation aide must be a certified nurse's aide, or have a related degree, or two years of college in a related field, or an approved 36-hour activity course and has received specified training as outlined and approved by the Department of Public Aid.

iii) For residents with a diagnosis of mental illness, if occupational rehabilitation is scored, a psychosocial and/or a corresponding ADL program must have been developed and scored.

H) Use of Paraffin Heat Treatments, Fluidotherapy, whirlpool may be scored when ordered by physician and carried out (Level 2 or 3 only).

I) Refer to 147.Table K for Occupational Therapy and Related Rehabilitative Services Measurement of Progress.

k) Category 11—Physical Therapy and Related Rehabilitation Services

1) Verification of Level of Service

A) Physician order (Level 1 or 2 only).

B) Assessment and program planned by the therapist.

C) Observation of rehabilitation aide conducting therapy sessions (Level 1 only).

D) Monthly review—progress documented by the PT or, if written by the rehabilitation aide, reviewed and co-signed by the PT.

E) Assessment every 90 days.

F) Corresponding ADL program or psychosocial (for MI diagnosis) program has been developed and implemented (Level 1 only).

G) Observation of PTA conducting therapy sessions (Level 2 only).

Observation of PT conducting therapy sessions (Level 3 only).

2) Need-Not-Met

A) Plan is not implemented as specified by the therapist.
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B) Goals are not designed to increase resident's functional capabilities.

C) Resident is not meeting goal(s) and clinical record does not indicate staff is addressing lack of progress.

D) Resident attended less than 85% of the scheduled sessions in the last three months or since the service began, if less than three months, and clinical record does not indicate resident’s absenteeism was due to illness or absence from the facility (Level 1 only).

E) Rehab aide is not a CNA or equivalent. Rehab aide has not received specified training, or has not been enrolled in a rehabilitation course as outlined and approved by IDPA within 90 days of the beginning date of employment in the rehab aide position (Level 1 only).

3) Agency-Note

A) Reimbursement for this item includes assessment done by registered PT.

B) The nurse case manager must verify the accuracy of the rehabilitation records by checking the clinical records of at least 25% of the residents in therapy, verifying services were delivered (Level 1 only).

C) If progress was not made within two months and goals or interventions were not changed, do not score.

D) Progress should be noted by standard acceptable PT objective measures.

E) Staffing ratios for rehabilitation 1:30 (per total enrollment)–98 minutes (Level 1 only). Staffing ratios for therapies for PT Level 2 and Level 3—1:1.5 (per 98 minutes).

F) Rehabilitation groups are limited to four residents with similar goals and levels of functioning (Level 1 only).

G) Prior to a resident being given credit in physical rehabilitation services, the following must be met (Level 1 only):

i) A corresponding ADL restorative program must be developed to increase the resident's functional ability and it must be carried out by the nursing department. The resident’s response to the intervention must be recorded in the clinical record.

ii) The physical rehabilitation aide must be a certified nurse aide, or have completed at least one year of nurses training and have received specified training as outlined and approved by the Illinois Department of Public Aid.
iii) For residents with a diagnosis of mental illness, if physical rehabilitation is scored, a psychosocial and/or a corresponding ADL program must have been developed and scored.

H) Refer to 147.Table K for Physical Therapy and Rehabilitative Services Measurement of Progress.

l) Category 12—Passive Range of Motion (PROM)

1) Verification of Level of Service
   A) Care plan or Treatment Sheet.
   B) Observation of resident to determine overall ability to use extremities.
   C) Observation of staff actually performing PROM and indication that plan is carried out regularly and routinely.
   D) Residents with existing contractures must have physician's orders although PROM for most residents does not require a physician's order.
   E) Monthly documentation of resident's response to intervention in clinical record. Documentation may be done by the staff providing the service.

2) Need Not Met
   A) Facility has no PROM protocol.
   B) The plan as indicated on the care plan or Treatment Sheet is not being implemented and documented.
   C) Documentation of resident's response to intervention is not documented in clinical record at least monthly.
   D) Resident has contractures or is at risk of developing contractures that are not being addressed.

3) Agency Note
   A) PROM that is also part of a pressure ulcer treatment and/or prevention program will be scored in both places.
   B) The required documentation should reflect the resident's response to treatment, i.e., resident is able to raise arm shoulder level; the resident remains contracture free.
   C) PROM protocol must address:
      i) Ongoing inservice education of direct care staff; and
      ii) On-going monitoring of PROM technique of direct care staff.
   D) CNA may document response to PROM if cosigned by licensed staff.

m) Category 13—Ostomy Care
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1) Verification of Level of Service
   A) Physician order
   B) Observation of ostomy care and a review of the treatment plan.

2) Need Not Met
   A) Facility does not have protocol for ostomy care.
   B) Staff does not adhere to physician's orders or facility's protocol and written procedures for ostomy care and maintenance.
   C) Excoriation observed with no indication in the clinical record and the plan of care is not altered.
   D) Care not performed by licensed personnel, other than routine change of colostomy bag.

3) Agency Note
   A) Colostomy bag can be changed by a CNA trained in ostomy care when allowed by facility protocol (Level 1 only).
   B) Facility protocol should address:
      i) On-going inservice education of direct care staff; and
      ii) On-going monitoring of technique of direct care staff.

n) Category 14—Respiratory Therapy

1) Verification of Level of Service
   A) Physician order must include: delivery system, oxygen flow rate and/or frequency of IPPB treatments, postural drainage, percussion and/or vibration and use of suctioning in conjunction with these therapies, if indicated.
   B) Observation of therapy.
   C) Documentation of procedure and results by licensed staff (Level 2).
   D) Monthly progress note by licensed staff (Level 2).

2) Need Not Met
   A) Facility does not have protocol for respiratory therapy.
   B) Respiratory therapy protocol is not being followed.
   C) Treatment is ordered, but not carried out as specified.
   D) Equipment soiled and/or nonfunctional or not available.
   E) Respiratory therapy not performed by licensed staff (Level 2).
   F) No monthly progress note by licensed staff (Level 2).

3) Agency Note
   A) Level 1 resident is capable of administering own therapy.
   B) Level 2 resident is totally dependent upon licensed staff for administration.
   C) Protocol should address:
      i) Which staff provide which type service;
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ii) Infection control procedures;
iii) Staff training required to carry out these services; and
iv) Frequency for assessment of respiratory status should be recorded in the clinical record.
v) Conditions or diagnoses which are indications and contraindications for the use of postural drainage, percussion and vibration.

D) Intensity code scoring is to reflect current level of needs.
E) Licensed personnel who carry out postural drainage, percussion and vibration shall have ongoing in service training by a respiratory therapist.
F) The use of postural drainage, percussion and vibration is restricted to those residents who produce 30cc or more of secretions daily.
G) A physician's order for postural drainage, percussion and vibration can be for a maximum of 30 days. The physician is then required to reevaluate the resident before a new order is written.
H) Suctioning which is done in conjunction with postural drainage, percussion and vibration is not to be scored under the suctioning category.
I) The care plan for residents who are in a program of postural drainage, percussion and vibration must include a pulmonary hygiene program which includes, but is not limited to, the following:
   i) Hydration
   ii) Nutrition
   iii) Rest
   iv) Absence of environmental pollutants.

o) Category 15—Suctioning
1) Verification of Level of Service
   A) Physician order.
   B) Observe treatment.
2) Need-Not-Met
   A) Facility does not have protocol for suctioning.
   B) Staff does not follow facility protocol.
   C) Care not performed by licensed personnel.
   D) Equipment soiled and/or nonfunctional and/or not readily available.
3) Agency-Note
   A) Facility's protocol should address guidelines for maintaining sterility and/or cleanliness of catheters.
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B) Suctioning done during tracheostomy care is included as part of tracheostomy care. Additional suctioning must be done at other times to be scored here.

C) Review last 30 days documentation to score this section.

D) Suctioning done in conjunction with postural drainage, percussion and vibration is not to be scored under the suctioning category.

p) Category 16—Tracheostomy Care

1) Verification of Level of Service
   Physician order.

2) Need Not Met
   A) Facility has no tracheostomy care protocol.
   B) Staff does not follow physician's order or facility's protocol for tracheostomy care.
   C) Care not performed by licensed personnel.
   D) An extra tracheostomy tube, the same size as the one in place, is not available at the bedside.
   E) Tracheostomy care is not documented.
   F) Equipment soiled and/or nonfunctional and/or not readily available.

3) Agency Note
   A) Protocol should address:
      i) Training licensed staff must have prior to providing this service;
      ii) Guidelines for infection control;
      iii) Frequency for observations of ostomy site and respiratory status should be recorded in the clinical record; and
      iv) Guidelines for maintaining sterility and/or cleanliness of catheters.
   B) Only suctioning done during tracheostomy care is scored here.

q) Category 17—Discharge Planning

1) Verification of Level of Service
   A) Care plan.
   B) Indication plan is being followed.

2) Need Not Met
   Plan not being followed.

3) Agency Note
   A) Discharge must be to less restrictive environment, i.e., shelter care, room and board or independent living arrangements and anticipated within three (3) months.
   B) Credit may be given for discharge planning if the service was
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received within the last six (6) months.

f) Category 18—Health & Fitness Program
1) Verification of Level of Service
A) Fitness card
B) Observation of program to see that the plan is being carried out as written on the fitness card.

2) Need-Not-Met
A) Health and Fitness program developed by unlicensed staff.
B) Plan not carried out.
C) Equipment required to carry out fitness program, as required on the fitness card, is soiled and/or nonfunctioning, or is not available.
D) The resident's response to intervention is not documented in the clinical record once a month.
E) Groups are larger than six (6) unless activity is a team sport.

3) Agency-Note
A) The program may also be developed by an Occupational Therapist, Physical Therapist, Certified Therapeutic Recreation Specialist, a Physician or Psychiatrist.
B) Do not score when resident does not carry out fitness program an average of three (3) times per week.
C) Activity programs including exercises must be separate and apart from health and fitness.
D) Fitness programs must address all extremities, unless contraindicated.
E) Unlicensed staff may document response to Health and Fitness Program if cosigned by licensed staff.

s) Category 19—Restraint Management and Reduction
1) Verification of Level of Service
A) Physician order
B) Assessment/reassessment at least every 90 days with program noted on care plan
C) Observation of resident
D) Monthly documentation of resident response cosigned by licensed staff

2) Need-Not-Met
A) A resident is physically restrained and there is no documentation of consultation with appropriate health professionals, such as physician, occupational therapist, physical therapist or rehabilitation certified registered nurse, in the use of less restrictive supportive devices or methods.
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B) Protocol not developed for restraint reduction and restraint management.

C) The resident is physically restrained and there is no documentation of consultation and agreement by the resident, family, if appropriate, guardian or legal representative to the use of restraints.

D) A resident is physically restrained and there is no assessment/documentation to justify restraint.

E) The restrained resident is not released at least every two hours for at least ten minutes, repositioned and exercised and/or ambulated and/or toileted and/or checked for skin redness and/or given nutrition/hydration as required.

F) Restraints are not applied according to physician order.

G) Resident restrained without physician order.

H) Restraint reduction program not implemented as specified in care plan.

I) Resident not meeting goals of the restraint reduction program and the clinical record does not indicate that the staff is addressing the lack of progress.

J) Resident response to restraint or reduction program is not documented in the clinical record at least monthly, reassessment not completed every 90 days, or not cosigned by licensed staff.

K) Restraint device is not clean, found to be in ill repair, or improperly sized.

L) Restraint device is not properly applied.

M) Facility not following protocol for care application, maintenance and reduction of each type of restraint used.

N) A resident placed in restraint is not checked at least every 30 minutes by staff trained in the use of restraints.

3) Agency Note
A) Residents who are free of restraints because of alternative programming are still eligible for scoring on Level 1, providing the quarterly reassessment continues to indicate that the specific staff intervention is needed to maintain the resident free of restraints, the need and intervention is specified in the care plan, and monthly documentation of resident response to intervention continues.

B) This item cannot be scored and a need not met can be given if:
   i) There is no physician order for the use of a restraint and the resident is restrained; OR
   ii) The restrained resident is not in a restraint program and the
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restraint is improperly applied; OR

iii) The restrained resident is not in a restraint program and is not released at least every two hours for at least ten minutes, repositioned and exercised and/or ambulated and/or toileted and/or checked for skin redness and/or given nutrition/hydration as required.

G) The facility must not issue orders for restraint on a standing or as needed basis.

D) Assessment includes, but is not limited to:

i) Reason for use of the restraint.

ii) Documentation of attempts made in ways of using less restrictive measures and why they were unsuccessful.

iii) Address communication needs and functional abilities.

E) Care plan includes, but is not limited to:

i) Alternative interventions used in place of restraints.

ii) If restraint must be used, include: reason for use of the restraint; type(s) of restraint used; duration and time of day restraint is used; location of resident when restrained, i.e., own room in bed, chair in hall, etc.; and under what circumstances are restraints being used, i.e., when left alone, after family leaves, when not involved in structured activity, when eating.

iii) Address communication needs and functional abilities.

F) Monthly response note should address functional and mental status of resident before, during and after use of restraints. Documentation of attempts made in ways of using less restrictive measures and why they were unsuccessful.

G) Physician order should include:

i) Reason for restraint;

ii) Length of time restraint is to be used; and

iii) Type of restraint to be used.

H) A resident should be released from restraints as soon as there is no longer a need.

I) A resident should not be physically or chemically restrained for the purpose of discipline or staff convenience.

J) Restraint usage should be periodically reevaluated and efforts to eliminate use of restraint should be attempted and documented in the clinical record. When the restraint usage is reevaluated, the functional status of the resident should be reviewed to ensure that no loss of function has occurred as a result of restraint usage. If a
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loss of function can be attributed to the use of the restraint, the facility should take prompt action to review restraint use with the physician to discuss alternative treatment.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE F  Social Services (Repealed)

<table>
<thead>
<tr>
<th>a) Verification of Level of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Initial (annual) assessment present and updated as needed every 90 days or sooner if the resident has experienced a significant change in status.</td>
</tr>
<tr>
<td>2) Initial history present and updated.</td>
</tr>
<tr>
<td>3) Social service needs identified on the assessment are addressed on care plan.</td>
</tr>
<tr>
<td>4) Quarterly notes (cosigned by a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, if necessary). (Level 1)</td>
</tr>
<tr>
<td>5) Monthly notes (cosigned by a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, if necessary). (Level 2)</td>
</tr>
<tr>
<td>6) Signed documentation that resident has been informed of his/her rights, initially and annually thereafter.</td>
</tr>
<tr>
<td>7) Signed documentation in records denoting that staff has counseled resident and/or family and/or guardian on Medicare/Medicaid programs (including prevention of spousal impoverishment), advance directives, medical services, community support services, personal allowances initially and annually thereafter and assisted with applications as needed.</td>
</tr>
<tr>
<td>8) Documentation of contacts made or attempted or services provided with resident's choice of pastoral care.</td>
</tr>
<tr>
<td>9) Copies of letters sent to family/guardian encouraging them to attend the care plan conference and/or family/guardian signature on care plan and/or documentation in the clinical record that the resident was encouraged to attend care plan conference.</td>
</tr>
<tr>
<td>10) Documentation that staff has counseled resident and/or family and/or guardian on resident council functions, purposes, etc.</td>
</tr>
<tr>
<td>11) Documented results of follow-up to standard monthly interview (Level 2).</td>
</tr>
</tbody>
</table>

b) Need-Not-Met
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1) Initial (annual) assessment not present, current or accurate.
2) Social history not present or current.
3) Identified needs not addressed on care plan.
4) No documentation that resident is informed of rights initially or annually.
5) No documentation that resident has been informed of Medicare/Medicaid or other community programs available initially and annually thereafter. No assistance given in applying for such services.
6) No documentation of attempts to secure choice of pastoral services.
7) No documentation of resident or family invitation to care plan conferences.
8) No documentation of attempts, at least annually, to involve resident in resident council.
9) No documentation of monthly resident interviews or follow-up to issues uncovered during the interview (Level 2 only).

e) Agency Notes

1) The standard social service interview should include questions concerning:
   A) Dining
   B) Schedule preferences
   C) Activity preferences, including recreation and social contacts, clubs and hobbies
   D) Outside contacts
   E) Money matters
   F) Care delivery
   G) Care planning
   H) Security and personal property
   I) Privacy
   J) Resident compliments and complaints
   K) Other social-service concerns
   L) Resident council
   M) Family involvement

2) Initial history should include, but is not limited to, occupational, educational and family history.

3) Social service designees (not a person with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals, but performing social work duties in facility) must have on-going consultation of licensed social worker, with notes cosigned by the licensed social worker or a person with a bachelor's degree in social work or a bachelor's degree in a human...
services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. Facilities shall also meet the social service requirements set forth in 77 Ill. Adm. Code 300.

4) If a resident, family or guardian is unable to attend a care conference, the facility provides an opportunity and documents efforts to discuss problems/issues with resident, family or guardian at least quarterly either by individual, family or guardian conferences, by letter or by phone.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147. TABLE H Determinations (Repealed)

INSTRUCTIONS: Circle Codes Y or N, or in #3, recommended level as appropriate under each item.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CODING SPECIFICATIONS</th>
<th>AGENCY NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)  Facility Referral</td>
<td>Y = Resident has unmet needs in functional or service areas or N’s circled under A: Physician Service Areas or D: Social Services and the facility must develop a plan for correction. N = Resident has no unmet needs and/or resident is not being referred to team physician for that review.</td>
<td></td>
</tr>
<tr>
<td>2)  Present Level of Care (Level currently certified)</td>
<td>1 = SNF 6 = Psychiatric Hospital 2 = ICF Sheltered care and Room and Board residents are not assessed during the IOC process.</td>
<td></td>
</tr>
<tr>
<td>3)  Recommended Level of Care</td>
<td>1 = SNF 5 = Acute general hospital 2 = ICF 6 = Psychiatric hospital 3 = Sheltered 7 = ICF/DD 4 = Room and Board 8 = ICF/MR (SNF/PED)</td>
<td></td>
</tr>
<tr>
<td>4)  Recommendation</td>
<td>1 = Resident is receiving appropriate level of care and may remain in this facility.</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Item</th>
<th>Coding Specifications</th>
<th>Agency Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Resident is not receiving appropriate level of care and must be transferred to another facility providing the level of care as indicated elsewhere on this form.</td>
<td>Each resident with a recommendation of 2 or 4, will be referred to the team physician.</td>
</tr>
<tr>
<td>3</td>
<td>Resident is not currently receiving appropriate level of care. Resident may remain in the facility. However, certified DPA 2448 is needed reflecting changed level of care.</td>
<td>DPA 2704 must be completed for a resident marked 2 or 4.</td>
</tr>
<tr>
<td>4</td>
<td>Resident has potential for discharge. Facility should proceed with discharge.</td>
<td>Each resident marked &quot;Y&quot; referral will be referred to the team physician. DPA 2704 must be completed for those residents marked &quot;Y.&quot;</td>
</tr>
</tbody>
</table>

5) Physician Referral

| Y    | Resident is being referred to the team physician for review. | Each resident marked "Y" referral will be referred to the team physician. DPA 2704 must be completed for those residents marked "Y." |
| N    | Resident is not being referred to the team physician for review. |

6) Negotiations

| Y    | The facility did indicate areas of dispute and did provide supportive documentation. |
| N    | The facility did not indicate areas of dispute and/or did not provide supportive documentation. |

7) Arbitration

| Y    | The facility is contesting some level of scoring on this form. | Forms 2700A/2700B must reflect each contested item with explanation. |
| N    | The facility is not contesting any level of scoring on this form. |

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26 ,2003)

Section 147.TABLE I Activities (Repealed)
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Adequate Activities

\[ \begin{align*}
\checkmark &= \text{The resident has a current activity plan of care and is receiving an appropriate activity program.} \\
\times &= \text{Activity needs of the resident are not being met by the facility.}
\end{align*} \]

MAKE BRIEF CONCISE STATEMENT REGARDING UNMET NEEDS AND/OR RECOMMENDATIONS.

Adequate Activities Needs Not Met

A. There is no assessment of activity needs.

B. Assessment does not reflect current interests and needs.

C. Initial activity plan has not been established.

D. Minimum standards for activities have not been met.

E. Activity plan has not been individualized.

F. Activities have not been incorporated into the interdisciplinary care plan.

G. Progress notes are not current (quarterly).

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147. TABLE J Signatures (Repealed)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CODING SPECIFICATIONS</th>
<th>AGENCY NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) HFSN ID NUMBER</td>
<td>NUMBER MUST BE WRITTEN IN THE FOLLOWING SEQUENCE.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>REGION NUMBER (TWO DIGITS) HFSN ID NUMBER (THREE DIGITS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e.g., 07140.</td>
<td></td>
</tr>
<tr>
<td>2) ASSESSMENT DATE</td>
<td>THE ASSESSMENT DATE MUST BE ENTERED AS A SIX (6) DIGIT NUMBER ON EACH FORM COMPLETED</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e.g., 09/08/86.</td>
<td></td>
</tr>
</tbody>
</table>
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3) **HFSN SIGNATURE**
   Full Name of Nurse Completing the Form.

4) **EXIT DATE**
   Date the Exit Conference Concluded. The exit date must be entered as a six (6) digit number on each form. e.g.: 09/09/86. This date must correspond to the last date in Section A-5, Date of Review, DPA 2702.

5) **SOCIAL WORKER ID NUMBER**
   Number must be written in the following sequence when there is a Social Worker Signature:
   Region Number (Two Digits) Social Worker ID Number (Three Digits)
   e.g.: 07098

6) **ASSESSMENT DATE**
   The Assessment Date must be entered as a six (6) digit number when there is a Social Worker Signature.
   e.g.: 09/08/86.

7) **SOCIAL WORKER SIGNATURE**
   Full Name of Social Worker (MAC II).

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

**Section 147. TABLE K Rehabilitation Services (Repealed)**

a) Occupational Therapy and Related Rehabilitative Services Measurement of Progress
   1) Independent Living/Daily Skills
      A) Physical Daily Living Skills (DLS). Measurable outcomes could include:
         i) Decreasing assistance to perform a specific task component of a DLS—not necessarily decreased assistance needed in the entire category.
            Example: Resident is able to lift cup off table to drink (may remain dependent in feeding).
         ii) Grading methods should show progression such as: unable to perform activity; activity requires maximal physical assistance (resident attempts to help but completes no part...
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of task); activity requires moderate physical assistance (resident able to do approximately 1/2 of activity); activity requires minimal physical assistance (resident able to do 3/4 of activity); activity requires supervision or verbal cues; or activity is performed appropriately, safely, independently, and consistently in a reasonable amount of time.

B) Psychological/Emotional Daily Living Skills

Measurable outcomes could include: decreasing exhibition of inappropriate behavior as shown through percentage of time or number of repetitions within a specified length of time; increasing exhibition of appropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.

Examples:

i) Decreases rocking to 25% of the day.

ii) Verbalizes less than three (3) self depreciatory or destructive statements per day.

iii) Contributes to group discussion 3 X in one hour session.

2) Sensorimotor Components

A) Measurable outcomes could include:

i) Reflex Integration: decreasing percentage of abnormal reflexes during occupational performance or task oriented activity.

ii) Range of Motion: goniometrics showing an increase in range of motion.

iii) Gross and Fine Coordination: effect of decreasing time on task completion, including percentage of task completed and/or number of repetitions completed. Effect of decreasing time on accuracy in task completion, including percentage of task completed and/or numbers of repetitions completed.

iv) Strength and Endurance: measurable outcomes could include:

1) increasing dynamometer measurements;

2) increasing amount of weight, load, resistance;

3) increasing number of repetitions;

4) increasing duration of tasks;

5) changes in heart rate, pulse rate, blood pressure, respirations per minute; and

6) manual muscle test.
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B) Sensory Integration
Sensory awareness, visual-spatial awareness, body integration, perception or differentiation of external and internal stimuli, as evidenced by objective measurements such as:* 

i) Decreases rocking to 25% of the day.

ii) Verbalizes less than three (3) self-depreciatory or destructive statements per day.

iii) Contributes to group discussion 3-X in one-hour session.

3) Cognitive Components
Measurable outcomes could include increased memory, problem solving, conceptualization, attention span as evidenced by objective measurements such as:

A) Number;

B) Duration;

C) Degree of performance; and

D) Decreased error of performance.

4) Psychosocial Components
Measurable outcomes could include:* 

A) Decreasing exhibition of inappropriate behavior as shown through percentage of time or number of repetitions within a specified length of time; and

B) Increasing exhibition of appropriate behavior as shown through percentage of time or number of repetitions within a specified length of time.

5) Therapeutic Adaptations
A) Orthotics/prosthetics; and

B) Assistive/adaptive equipment.

C) Measurable outcomes could include:* 

i) Increased Range of Motion (ROM);

ii) Decreased contractures;

iii) Prevention of further contractures;

iv) Increased functional use; and

v) Competency in use of equipment towards increased function.

NOTE: Staff requirements include provision of equipment such as splints, prosthetics, and orthotic devices.

* Measure against a functional expectation considering the age and projected potential of each resident.

b) Physical Therapy and Related Rehabilitative Services Measurement of Progress
1) Goniometrics—measuring ROM in degrees
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2) Manual muscle test (MMT) measure of muscle strength:

0  zero
1  trace
2  poor
3  fair
4  good
5  normal
+  greater-than
-  less-than

3) Increasing repetitions.
4) Increasing distance.
5) Balance measured by muscle strength: poor, fair, good, normal.
6) Changing gait deviation to improve functional ambulation.
7) Progression to a less restrictive assistive device.

c) Speech Language Pathology/Audiology Rehabilitative Services Measurement of Progress

Types of modalities and activities which are typical for gaining functional abilities in geriatric population include but are not limited to:

1) Auditory Comprehension
   A) Comprehension and understanding of common, functional words;
   B) Comprehension and completion of directives;
   C) Comprehension and concepts of time, place, description, etc.; and
   D) Comprehension and conversation, subtleties of language, meaning, etc.

2) Speech Production
   A) Improvement of oral-motor skills;
   B) Production of isolated sounds (phonemes);
   C) Production of sounds in syllables, words, phrases, connected speech;
   D) Ability to use an appropriate vocal-level with adequate breath support; and
   E) Ability to utilize appropriate vocal quality for intelligible speech.

3) Expression
   A) Ability to name (imitatively-spontaneously) common, functional items;
   B) Ability to verbally produce meaningful and functional utterances (imitatively, spontaneously, self-initiated); and
   C) Ability to express wants/needs, etc. through alternative means of
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communication (i.e. communication board, electronic
communication device, etc.).

4) Aural Rehabilitation
Goals established only after an audiologic evaluation has been completed.
A resident who exhibits a moderate to severe loss of hearing (i.e., 50dB
SRT (Speech Reception Threshold) or greater loss in the better ear and/or
an aided discrimination score of less than 70% accuracy in the aided ear)
would be eligible for an Aural Rehabilitation Program:
A) Ability to achieve speech reading skills;
B) Ability to discriminate words, sounds, etc. for effective
comprehension;
C) Ability of resident to achieve more independent operation of the
hearing aid; and
D) Ability of residents to effectively and independently utilize
environmental controls to compensate for their loss of hearing (i.e.
eye contact, preferential seating, utilize better ear, etc.).

5) Voice Disorders
A) Achieve appropriate balance of oral/nasal resonance for effective
communication;
B) Achieve use of proper vocal intensity, pitch or vocal quality for
effective communication;
C) Achieve effective use of esophageal speech (for laryngectomized
residents); and
D) Achieve use of appropriate augmentative system of
communication when indicated (use of electrolarynx, etc., for
laryngectomized resident).

d) Progress is indicated when the following types of notation are observed in a
resident's chart:
1) There is a decrease in the number of repetitions of directives or models
required in order to achieve task completion.
2) There is a decrease in the number of cues required in order to achieve task
completion. A cue is any verbal or nonverbal signal which stimulates task
completion (i.e. residents with word finding problems may require cueing
of an open ended sentence, residents with motor/speech problems may
require a cue of oral configuration, etc.).
3) Tasks are completed in a more independent manner. Abilities to complete
a skill move along a hierarchy from totally dependent to independent use
of a skill:
A) Imitative;
B) Cued;
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4) Tasks move in a hierarchy of the types of errors made in patient’s/resident’s responses:
A) Totally incorrect response;
B) Related error;
C) A response requiring a repeat of directives or a cue;
D) Self-corrected response;
E) Incomplete response;
F) Delayed response; and
G) Complete independent immediate response.

5) Tasks are completed in a hierarchy of complexity of resident’s response:
A) Verbal Expression
   i) imitation of word
   ii) single-word production from cue
   iii) independent production of single word
   iv) use of word in a structured phrase
   v) use of words in a nonstructured phrase
   vi) use of words in a nonstructured sentence
   vii) use in independent sentences in connected utterances
   viii) self initiation of thoughts, wants, needs, feelings, etc.
B) Motor Speech
   i) imitation of oral postures;
   ii) imitation of phonemes in isolation;
   iii) imitation of phonemes in single-syllable contexts;
   iv) spontaneous production in single-syllable contexts;
   v) imitation in single words;
   vi) spontaneous production in singel syllable contexts;
   vii) imitation of the word in phrase;
   viii) spontaneous production of the word in phrase; and
   ix) spontaneous self-initiated production in connected speech.
C) Dysphagia
   i) able to effect a lip seal to hold bolus in oral cavity;
   ii) able to maintain adequate jaw range of motion for mouth opening (up/down) and chewing (rotary), adequate tongue range of movement to: a) hold bolus; b) manipulate bolus; c) propel bolus into the pharynx;
   iii) able to trigger a swallow reflex within one second;
   iv) able to move food through the pharynx to the esophagus;
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v) able to protect the airway well enough to prevent aspiration during a swallow (maintain complete laryngeal closure);
vii) able to tolerate pureed consistencies by mouth for primary or supplemental nutrition;
viii) able to tolerate masticated consistencies by mouth for primary or supplemental nutrition;
ix) able to coordinate a cough to clear residue from the pharynx or larynx;
xi) able to learn the supraglottic swallow;
xii) able to learn to coordinate postural change and tongue and laryngeal involvement.

6) There is an increase in the percentage of correct responses observed in the resident's completion of tasks.

7) There is an increase in the resident's level of functioning as demonstrated by formal testing (i.e. higher verbal scores for expressive language disorders, improved scores in tests of speech reading for aural rehabilitation patients, etc.).

8) Resident's skills become more functional in nature and are generalized and carried over to contexts outside of the therapeutic environment.

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147. TABLE L  Personal Information (Repealed)

Indicated below are requirements and corresponding time frames which must be met by Long Term Care facilities and will be verified by the case manager during the Inspection of Care survey.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CODING SPECIFICATIONS</th>
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<tbody>
<tr>
<td>1)</td>
<td>Plan of care <strong>Y</strong></td>
<td>The plan of care is up-to-date according to the time frame: At the time of admission, the physician initially establishes the plan of care through the history, physical exam, functional level, objectives, orders and</td>
</tr>
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personnel must review the plan at least every 90 days or as needed. plans for continuing care and discharge. This includes the resident care plan.

\[ N = \text{The plan of care is not up-to-date.} \]

2) Physicians' certification/recertification

\[ Y = \begin{align*}
\text{The physician certified at the time of admission and recertified according to the time frame.} \\
\text{SNF—30/60/90 days after initial certification, and every 60 days thereafter.} \\
\text{ICF—60 days/180 days/12 months/18 months/24 months after initial certification, every 12 months thereafter.} \\
\text{ICF-DD—every 12 months after initial certification.}
\end{align*} \]

NOTE: See Form 2448, Physician Certification or an alternate form in the medical record. If alternative form used, location of current certification must be documented on DPA 2448. If items 11-14 are marked "N", make a facility referral.

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<tr>
<td>[ N = \text{Resident not initially certified or recertified at required intervals.} ]</td>
<td>Certification if after the date of admission and if no eligible date is on 2448; or Eligible date is before signature date; or No-Recipient-Identification-Number and/or no Case Identification Number.</td>
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3) Physicians' progress notes/visits

\[ \text{\textbf{Y} = Progress notes for skilled care must be updated once every 30 days for the first 90 days following admission. After the first 90 day period has passed, an alternate review schedule may be adopted. Alternate review schedules of progress notes must not exceed 60 days. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.} \]

\[ \text{\textbf{Y} = Progress notes for intermediate care must be updated once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.} \]

\[ \text{\textbf{N} = Progress notes not updated within required intervals listed above.} \]

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<td>4)</td>
<td>Physician's medication review</td>
<td>[ \text{\textbf{Y} = Physician has reviewed medications within the last 30 days for SNF and 90 days for ICF residents.} ]</td>
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(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)
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1) **Heading of the Part:** Hospital Services

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

3) **Section Numbers:**
   - 148.140 Amendment
   - 148.160 Amendment

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

5) **Effective Date of Amendments:** November 26, 2003

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

7) **Do these amendments contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 18, 2003 (27 Ill. Reg. 10640)

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

11) **Differences Between Proposal and Final Version:** Section 148.295 has been deleted from the proposed rulemaking for the following reason: the fiscal year 2004 budget implementation plan required additional changes under Critical Hospital Adjustment Payments (Section 148.295) to take effect on October 1, 2003. New emergency provisions in 89 Ill. Adm. Code 148, including Section 148.295, were effective on October 1, 2003 (published on October 24, 2003, at 27 Ill. Reg. 16268). Identical proposed amendments were published on August 29, 2003, at 27 Ill. Reg. 14090, to meet federal public notice requirements. Therefore, the proposed changes to Section 148.295 that were published at 27 Ill. Reg. 10640, are no longer necessary.

   No other substantive changes have been made.

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 these amendments replace emergency amendments currently in effect?** Yes
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14) Are there any other amendments pending on this Part? Yes

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<td>Amendment</td>
<td>August 29, 2003 (27 Ill. Reg. 14090)</td>
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<td>148.122</td>
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15) Summary and Purpose of Amendments: These amendments provide several fiscal year 2004 budget implementation changes to the Department's rules regarding hospital services. The changes eliminate automatic rate adjustment increases for outpatient and inpatient services that are provided in certain county owned clinics and hospitals, and allow the Department to adjust payments quarterly for certain county owned hospitals. These changes are intended to maintain compliance with federal payment limitations under Medicaid while allowing the flexibility necessary to maximize federal matching payments for the State.

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

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

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

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS
PART 148
HOSPITAL SERVICES

SUBPART A: GENERAL PROVISIONS
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148.390 Hearings
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148.500 Definitions
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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. 18851, effective November 26, 2003.

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.140 Hospital Outpatient and Clinic Services

a) Fee-For-Service Reimbursement

1) Reimbursement for hospital outpatient services shall be made on a fee-for-service basis, except for:

A) Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection (b) 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).

D) Those services provided by a Critical Clinic Provider as described in subsection (e) of this Section.

2) Except for the procedures under the APL groupings described in subsection (b) 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) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

3) 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) Maternal and Child Health Program 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.
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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) Ambulatory Procedure Listing (APL)
Effective July 1, 2002, 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 procedure 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 procedure 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
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brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate for this procedure 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. The rate for this procedure 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 procedure 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 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 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 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
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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.
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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.
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F) Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services. Under this group, the Department will reimburse for services provided by a hospital enrolled with the Department to provide outpatient-physical rehabilitation services at a different rate than will be reimbursed for physical rehabilitation services provided by a hospital that is not enrolled with the Department to provide physical rehabilitation services. 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 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 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.
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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, except that physical rehabilitation services provided by a general care hospital not enrolled with the Department to provide outpatient physical rehabilitation services shall be reimbursed at a rate of $230.00 and the reimbursement rate for Type B psychiatric clinic services shall be $224.00. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by
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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.

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, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection (b)(1)(F) of this Section. 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 subsection (b)(1) 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 which resulted in a zero
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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.
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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) No Year-End Reconciliation
With the exception of the retrospective rate adjustment described in subsection (b)(8) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

7) 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.

8) 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) which 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.

9) 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.

c) 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 which 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 which 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.
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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.

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
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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
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(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
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of services available to those clients) which 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 which 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 27 Ill. Reg. 18851, effective November 26, 2003)

Section 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million

a) Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(c)(8), county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this Section.

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.
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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).

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.

c) 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
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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 is 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.
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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
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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 under all medical programs administered by the Department except the Family and Children Assistance Program, formerly known as the General Assistance Program, and shall be 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.
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(Source: Amended at 27 Ill. Reg. 18851, effective November 26, 2003)
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1) **Heading of the Part:** Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

2) **Code Citation:** 89 Ill. Adm. Code 149

3) **Section Number:** 149.50  **Adopted Action:** Amendment

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-0040

5) **Effective Date of Amendment:** November 26, 2003

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

7) **Does this amendment contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 18, 2003 (27 Ill. Reg. 10643)

10) **Has JCAR issued a Statement of Objection to this rulemaking?** No

11) **Differences Between Proposal and Final Version:** No substantive changes have been made to this proposed rulemaking.

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 amendment replace any emergency amendments currently in effect?** Yes

14) **Are there any other amendments pending on this Part?** Yes

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15) **Summary and Purpose of Amendment:** In accordance with Public Act 93-40, this amendment revises the definition of a children's hospital. The changes will increase the
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The number of facilities that are able to meet the qualification criteria of a hospital devoted to caring for children and thereby enhance access for children to necessary medical care.

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

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

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

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)
149.10 Applicability of Other Provisions
149.25 General Provisions
149.50 Hospital 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 Prospective Payment Rates
149.105 Payment For Outlier Cases
149.125 Special Treatment of Certain Facilities
149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
149.150 Payments to Hospitals Under the DRG Prospective Payment System
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)
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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)


Section 149.50 Hospital Services Subject to and Excluded from the DRG Prospective Payment System

a) 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)
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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 and Exempted Hospitals and Hospital Units: General Rules

1) 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.

2) 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.

c) 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
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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,
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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, if separately licensed as a hospital by a municipality before September 30, 1998, shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children. A children's hospital licensed by a municipality 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.

B) Have a Provider Agreement to participate in the Medicaid Program.

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.
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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 27 Ill. Reg. 18880, effective November 26, 2003)
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1) Heading of the Part: Long Term Care Reimbursement Changes

2) Code Citation: 89 Ill. Adm. Code 153

3) Section Numbers: Adopted Action:
   153.100 Amendment
   153.125 Amendment

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

5) Effective Date of Amendments: November 26, 2003

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

7) Do these amendments contain incorporations by reference? No

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

9) Notice of Proposal Published in Illinois Register: July 18, 2003 (27 Ill. Reg. 10645)

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences Between Proposal and Final Version: No changes have been made to this proposed rulemaking.

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 these amendments replace any emergency amendments currently in effect? Yes

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

15) Summary and Purpose of Amendments:

   Section 153.100

   Pursuant to Public Act 92-0848, the Department is establishing a new methodology for the nursing component of rates for Medicaid funded nursing facilities (NFs). Skilled nursing facilities and intermediate care facilities that are licensed under the Nursing
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Home Care Act and certified under the Medicaid Program will be affected by the new payment provisions. For the nursing component, the Department will use the Minimum Data Set (MDS), a federally required assessment form, to collect information from nursing facilities concerning the condition of NF residents and establish a rate based on all Medicaid residents in the NF. The nursing component will be calculated and adjusted on a quarterly basis.

In accordance with the Act, the Department has developed the new rate methodology under which new payments are subject to appropriation levels provided by the General Assembly. Any increases will only be effective if specific appropriation is made for this purpose. A transition period of two years, beginning July 1, 2003, will be provided for initial implementation of the new payment methodology. During this period, for an NF that would receive a lower nursing component rate under the new system than under the current system, the nursing component rate will be held at the current rate until a higher rate is achieved by that NF. Companion amendments are being filed at 89 Ill. Adm. Code 140 and 147. Because of the MDS based rate system, the Department's rules relating to Inspection of Care for NFs are being repealed or amended.

If there is no specific appropriation for this purpose, there is no annual budgetary impact resulting from these rate changes. Public Act 92-848 states that rates under the new methodology shall be adjusted subject to appropriations provided by the General Assembly. If and when monies are made available, they will be distributed as allocated in these proposed amendments: first to restore the 5.9% reduction from FY 2003, then to distribute monies according to the new methodology. Nothing in these amendments should be construed as suggesting that these new monies are currently available or will be made available at any point in the future.

Section 153.125

These changes pertain to nursing facilities, intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), and providers of developmental training services. The changes are being filed pursuant to Public Act 93-20 and Public Act 93-14. Rates for nursing facilities shall be maintained at the levels in effect on June 30, 2003. Rates for ICFs/MR shall be 3.59 percent more, and rates for developmental training shall be 4 percent more, than the rates in effect on June 30, 2003. ICF/MR spending will affect the Illinois Department of Human Services, which is the designated State agency responsible for ICF/MR health standards and reimbursement.

16) Information and questions regarding these adopted amendments shall be directed to:
DEPARTMENT OF PUBLIC AID

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

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

TITLE 89:  SOCIAL SERVICES
CHAPTER I:  DEPARTMENT OF PUBLIC AID
SUBCHAPTER e:  GENERAL TIME-LIMITED CHANGES

PART 153
LONG TERM CARE REIMBURSEMENT CHANGES

Section
153.100  Reimbursement for Long Term Care Services
153.125  Long Term Care Facility Rate Adjustments
153.150  Quality Assurance Review (Repealed)


SOURCE:  Emergency rules adopted at 18 Ill. Reg. 2159, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10154, effective June 17, 1994; emergency amendment at 18 Ill. Reg. 11380, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16669, effective November 1, 1994; emergency amendment at 19 Ill. Reg. 10245, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16281, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9306, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14840, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 9568, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13633, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 13114, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16285, effective August 28, 1998; amended at 22 Ill. Reg. 19872, effective October 30, 1998; emergency amendment at 23 Ill. Reg. 8229, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12794, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13638, effective November 1, 1999; emergency amendment at 24 Ill. Reg. 10421, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15071, effective October 1, 2000; emergency amendment at 25 Ill. Reg. 8867, effective July 1, 2001, for
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a maximum of 150 days; amended at 25 Ill. Reg. 14952, effective November 1, 2001; emergency amendment at 26 Ill. Reg. 6003, effective April 11, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 12791, effective August 9, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11087, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17817, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 11088, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18888, effective November 26, 2003.

Section 153.100  Reimbursement for Long Term Care Services

a) Notwithstanding the provisions set forth in 89 Ill. Adm. Code 140, 144 and 147 for reimbursement of long term care services, effective January 18, 1994, reimbursement rates for long term care facilities (SNF/ICF and ICF/MR) and day training providers will remain at the levels in effect on January 18, 1994, except as otherwise provided in this Section. b) The results of Inspection of Care (IOC) surveys for which the exit conference is completed prior to January 18, 1994, will be processed and reflected in facility rates effective with the annual nursing rate adjustment date. The reconsideration process which is provided for in 89 Ill. Adm. Code 147.100 remains in effect for these surveys and other surveys set forth in this Section.

c) Capital and support rates in effect on January 18, 1994, will be adjusted based on final audits of cost report data in accordance with 89 Ill. Adm. Code 140.582(b) and 140.590.

d) Capital rates will be increased for major capital improvements in accordance with 89 Ill. Adm. Code 140.560(c) and (e).

e) New facilities which are assigned median rates in accordance with 89 Ill. Adm. Code 140.560(b) will have rates recalculated based upon receipt of their first cost report and 89 Ill. Adm. Code 147.150 first IOC survey. f) Rates may change based upon an interim IOC conducted at the facility's written request for any facility which changed ownership no earlier than 90 days prior to and not later than January 18, 1994. The interim IOC request must include justification and documentation which supports one of the criteria set forth in 89 Ill. Adm. Code 147.150(d). g) Requests for interim IOCs received through January 18, 1994, will be processed in accordance with 89 Ill. Adm. Code 147.150(d). h) Interim IOCs may be conducted, at the facility's written request, if there has been a change in the Medicaid census since the last IOC survey in accordance with 89 Ill. Adm. Code 147.150(d), except that the requirement that the request must be made
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within 180 days after the last IOC, need not be met. The written request must contain documentation supporting the change in Medicaid census. i) The Department reserves the right to initiate interim IOC surveys, if necessary, based upon a significant reduction in the level of resident care or for the health and safety concerns of residents. j) Any rate adjustments that result from an interim IOC conducted under this Section will have an effective date of the first day of the month following the exit date of the interim IOC.

e) Requests for IOCs upon which rate determinations are based upon a Medicaid resident being transferred from a State operated facility for persons with developmental disabilities to a community setting will be considered on a case-by-case basis.

f) Fiscal year 1996 support rates may change based on the first cost report filed by new ownership reflecting six months or more of the new ownership's operation for any facility which changed ownership between July 1, 1992, and January 18, 1994. Only changes in ownership in arms-length transactions between unrelated parties will be recognized for this rate change. The new support rate for those facilities will be calculated in accordance with 89 Ill. Adm. Code 140.560 and 140.561. Support rates for facilities which qualify under this exception will not be decreased by the provisions in this Section. The capital rates of facilities which changed ownership between July 1, 1992, and January 18, 1994, will not be subject to changes in the capital rate based on the provisions of 89 Ill. Adm. Code 140.571(b)(4), but can still be affected by the provisions of subsection (d) of this Section.

g) For those for-profit facilities whose fiscal year 1994 capital rate does not include a real estate tax component because it is based upon a non-profit facility's cost report, effective July 1, 1995, the real estate tax component will be added to the capital rate based upon the fiscal year 1994 median real estate tax rate for the geographic area in which the home is located.

h) If a non-profit facility changes ownership on or after July 1, 1995, and the new owner is a for-profit facility, the real estate tax component will be added to the capital rate effective with the change of ownership as recognized by the Illinois Department of Public Health. The real estate tax component will be added at the geographic area median tax rate in effect for the month in which the real estate tax becomes effective.

i) For those non-profit facilities whose fiscal year 1994 capital rate includes a real
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estate tax component based upon a for-profit facility's cost report, effective July 1, 1995, the real estate tax component of the capital rate will be removed (unless the non-profit facility rents the home from an unrelated for-profit entity).

j) If a for-profit facility changes ownership on or after July 1, 1995, and the new owner is a non-profit facility, the real estate tax component will be removed from the capital rate effective with the date of change in ownership as recognized by the Illinois Department of Public Health. The real estate tax component will not be removed for a non-profit facility that rents the facility from an unrelated for-profit entity.

k) Rates may change based upon verification of the delivery or non-delivery of psychiatric rehabilitation services to individuals with mental illness residing in nursing facilities. Psychiatric rehabilitation services program reimbursement will be dependent upon the facility meeting all criteria specified in 89 Ill. Adm. Code 147.300 through 147.345.

l) The flat per diem paid to ICFs/MR to cover the cost of non-emergency dental services pursuant to 89 Ill. Adm. Code 144.275 and 144.300 will be increased from $.30 to $.40.

m) Day training provider rates shall be increased by three percent for services provided on or after July 1, 1996.

n) Effective for services provided on or after July 1, 1996, facilities which are located in an area which has changed geographic designation due to unique labor force factors shall have rates recalculated based upon the ceiling and norms of the newly designated geographic area.

o) The add-on to the final nursing rate for care planning identified in 89 Ill. Adm. Code 147.205 will be increased from $.35 to $.45.

p) Long term care facilities that have been assigned a median tax rate on the basis of geographic area in accordance with 89 Ill. Adm. Code 140.560(b) and subsections (m) and (n) of this Section shall subsequently have those rates recalculated based upon the first full tax bill received by that facility. The revised rate will be the greater of the recalculated rate or the rate in effect from the aforementioned Section and subsections. Rates revised in accordance with this subsection shall result in payments retroactive to July 1, 1997, for those facilities whose first full tax bill is received by the Department no later than September 30, 1998. Rates for facilities whose first full tax bill is received after September 30, 1998, will be effective on the date the Department receives the first full tax bill. In order to calculate the potential tax rate, the real estate tax from the first full tax bill for the
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long term care property will be divided by the greater of the annualized capital
days (see 89 Ill. Adm. Code 140.570(b)(3)) from the cost report used to calculate
the remainder of the capital rate in accordance with 89 Ill. Adm. Code 140.570
through 140.574, or 93 percent of annualized bed days based upon the number of
licensed beds available at the end of the period covered by the tax bill. No
inflation factor will be used for this calculation.

Interim IOCs may be conducted in an ICF/MR, at the facility's written request, if
there has been a change in the resident population of at least 25 percent since the
last IOC used to set the rate. A facility is limited to one request in any 12 month
period. The rate effective date will be the first day of the month following the
month of the facility's written request. The written request must contain
documentation supporting the change in the resident population.

Interim IOCs may be conducted for developmental training services when the
population of an ICF/MR changes by at least 25 percent since the last IOC used to
set the rate. The ICF/MR is limited to one request in any 12 month period. The
rate effective date will be the first day of the month following the month of the
facility's written request. Documentation must be submitted supporting the
change in the resident population.

Rates shall be adjusted for an ICF/MR entering into a downsizing agreement with
the Department of Human Services, under the provisions of 89 Ill. Adm. Code
140.560, with the rate effective on the date a benchmark for such downsizing is
achieved.

For an ICF/MR with 16 or fewer licensed beds, rate changes shall be made in the
program active treatment rate component to reflect an increase of 13 hours of base
nursing and nurse supervision for administration of medication by unlicensed
direct service staff, effective for services provided on or after January 1, 2000.

The nursing component of a nursing facility's per diem shall be adjusted in
accordance with 89 Ill. Adm. Code 147.150.

(Source: Amended at 27 Ill. Reg. 18888, effective November 26, 2003)

Section 153.125 Long Term Care Facility Rate Adjustments

Notwithstanding the provisions set forth in Section 153.100, long term care
facility (SNF/ICF and ICF/MR) rates established on July 1, 1996, shall be
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increased by 6.8 percent for services provided on or after January 1, 1997.

b) Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1998, for services provided on or after that date, shall be increased by three percent. For nursing facilities (SNF/ICF) only, $1.10 shall also be added to the nursing component of the rate.

c) Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1999, for services provided on or after that date, shall include:

1) an increase of 1.6 percent for SNF/ICF, ICF/MR and developmental training rates;

2) an additional increase of $3.00 per resident day for ICF/MR rates; and

3) an increase of $10.02 per person, per month for developmental training rates.

d) Notwithstanding the provisions set forth in Section 153.100, SNF/ICF rates shall be increased by $4.00 per resident day for services provided on or after October 1, 1999.

e) Notwithstanding the provisions set forth in Section 153.100, SNF/ICF, ICF/MR and developmental training rates shall be increased 2.5 percent per resident day for services provided on or after July 1, 2000.

f) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on July 1, 2001, and each subsequent year thereafter, shall be computed using the most recent cost reports on file with the Department no later than April 1, 2000, updated for inflation to January 1, 2001.

1) The Uniform Building Value shall be as defined in 89 Ill. Adm. Code 140.570(b)(10), except that, as of July 1, 2001, the definition of current year is the year 2000.

2) The real estate tax bill that was due to be paid in 1999 by the nursing facility shall be used in determination of the capital component of the rate. The real estate tax component shall be removed from the capital rate if the
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facility's status changes so as to be exempt from assessment to pay real estate taxes.

3) Wages shall be calculated according to 89 Ill. Adm. Code 147.150, except that wages will be updated for inflation to January 1, 2001.

4) Capital and support rates in effect on July 1, 2001, shall be adjusted based on audits of cost report data in accordance with 89 Ill. Adm. Code 140.582(b) and 140.590.

5) For rates effective July 1, 2001, only, rates shall be the greater of the rate computed for July 1, 2001, or the rate effective on June 30, 2001.

6) All accounting records and other documentation necessary to support the costs and other information reported on the cost report to be used in accordance with rate setting under Section 153.125(f) shall be kept for a minimum of two years after the Department's final payment using rates that were based in part on that cost report.

g) Notwithstanding the provisions set forth in Section 153.100, intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled nursing facilities for persons under 22 years of age (SNF/Ped), shall receive an increase in rates for residential services equal to a statewide average of 7.85 percent. Residential rates taking effect March 1, 2001, for services provided on or after that date, shall include an increase of 11.01 percent to the residential program rate component and an increase of 3.33 percent to the residential support rate component, each of which shall be adjusted by the geographical area adjuster, as defined by the Department of Human Services (DHS).

h) For developmental training services provided on or after March 1, 2001, for residents of long term care facilities, rates shall include an increase of 9.05 percent and rates shall be adjusted by the geographical area adjuster, as defined by DHS.

i) Notwithstanding the provisions set forth in Section 153.100, daily rates for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 2.247 percent for services provided during the period beginning on April 11, 2002, and ending on June 30, 2002.
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j) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2002, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be reduced to the level of the rates in effect on April 10, 2002.

k) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on July 1, 2002 will be 5.9 percent less than the rates in effect on June 30, 2002.

l) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2003, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 3.59 percent.

m) Notwithstanding the provisions set forth in Section 153.100, developmental training rates effective on July 1, 2003, shall be increased by 4 percent.

(Source: Amended at 27 Ill. Reg. 18888, effective November 26, 2003)
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1) **Heading of the Part:** Child Support Enforcement

2) **Code Citation:** 89 Ill. Adm. Code 160

3) **Section Number:** 160.60  
   **Adopted Action:** Amendment

4) **Statutory Authority:** Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 93-148

5) **Effective Date of Amendment:** November 26, 2003

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

7) **Does this amendment contain incorporations by reference?** No

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

9) **Notice of Proposal Published in Illinois Register:** July 25, 2003 (27 Ill. Reg. 12016)

10) **Has JCAR issued a Statement of Objection to this rulemaking?** No

11) **Differences Between Proposal and Final Version:** No substantive changes have been made to the proposed rulemaking.

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 amendment replace any emergency amendments currently in effect?** Yes

14) **Are there any other amendments pending on this Part?** Yes

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<th>Sections</th>
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<td>Amendment</td>
<td>October 10, 2003 (27 Ill. Reg. 15688)</td>
</tr>
<tr>
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<td>Amendment</td>
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<td>Amendment</td>
<td>October 10, 2003 (27 Ill. Reg. 15688)</td>
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15) Summary and Purpose of Amendment: This amendment responds to Public Act 93-148 concerning child support amounts that are due from supporting parties. In accordance with the Act, courts shall determine the minimum support amount for two children on the basis of guidelines which increase the amount from 25 percent to 28 percent of the supporting party's net income.

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

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

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

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER f: COLLECTIONS

PART 160
CHILD SUPPORT ENFORCEMENT

SUBPART A: GENERAL PROVISIONS

Section
160.1 Incorporation by Reference
160.5 Definitions
160.10 Child Support Enforcement Program
160.12 Administrative Accountability Process
160.15 Application Fee for IV-D Non-TANF Cases
160.20 Assignment of Rights to Support
160.25 Recoupment

SUBPART B: COOPERATION WITH CHILD SUPPORT ENFORCEMENT

Section
160.30 Cooperation With Support Enforcement Program
160.35 Good Cause for Failure to Cooperate with Support Enforcement
160.40 Proof of Good Cause For Failure to Cooperate With Support Enforcement
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160.45 Suspension of Child Support Enforcement Upon a Claim of Good Cause

SUBPART C: ESTABLISHMENT AND MODIFICATION OF
CHILD SUPPORT ORDERS

Section
160.60 Establishment of Support Obligations
160.61 Uncontested and Contested Administrative Paternity and Support Establishment
160.62 Cooperation with Paternity Establishment and Continued Eligibility Demonstration Program (Repealed)
160.65 Modification of Support Obligations

SUBPART D: ENFORCEMENT OF CHILD SUPPORT ORDERS

Section
160.70 Enforcement of Support Orders
160.71 Credit for Payments Made Directly to the Title IV-D Client
160.75 Withholding of Income to Secure Payment of Support
160.77 Certifying Past-Due Support Information or Failure to Comply with a Subpoena or Warrant to State Licensing Agencies
160.80 Amnesty – 20% Charge (Repealed)
160.85 Diligent Efforts to Serve Process
160.88 State Case Registry

SUBPART E: EARMARKING CHILD SUPPORT PAYMENTS

Section
160.90 Earmarking Child Support Payments

SUBPART F: DISTRIBUTION OF SUPPORT COLLECTIONS

Section
160.95 State Disbursement Unit
160.100 Distribution of Child Support for TANF Recipients
160.110 Distribution of Child Support for Former AFDC or TANF Recipients Who Continue to Receive Child Support Enforcement Services
160.120 Distribution of Child Support Collected While the Client Was an AFDC or TANF Recipient, But Not Yet Distributed at the Time the AFDC or TANF Case Is Cancelled
160.130 Distribution of Intercepted Federal Income Tax Refunds
160.132 Distribution of Child Support for Non-TANF Clients
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160.134 Distribution of Child Support For Interstate Cases
160.136 Distribution of Support Collected in IV-E Foster Care Maintenance Cases
160.138 Distribution of Child Support for Medical Assistance No Grant Cases

SUBPART G: STATEMENT OF CHILD SUPPORT ACCOUNT ACTIVITY

Section
160.140 Statement of Child Support Account Activity

SUBPART H: DEPARTMENT REVIEW OF DISTRIBUTION OF CHILD SUPPORT

Section
160.150 Department Review of Distribution of Child Support for TANF Recipients
160.160 Department Review of Distribution of Child Support for Former AFDC or TANF Recipients


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SUBPART C: ESTABLISHMENT AND MODIFICATION OF CHILD SUPPORT ORDERS

Section 160.60 Establishment of Support Obligations

a) Definitions

1) "FSS" means any Family Support Specialist performing assigned duties, his supervisory staff and any other person assigned responsibility by the Director of the Department.

2) "Service" or "Served" means notice given by personal service, certified mail, restricted delivery, return receipt requested, or by any method provided by law for service of summons. (See Sections 2-203 and 2-206 of the Code of Civil Procedure [735 ILCS 5/2-203 and 2-206].)

3) "Support Statutes" means the following:
   A) Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X];
   B) The Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5];
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C) The Non-Support Punishment Act [750 ILCS 16];

D) The Uniform Interstate Family Support Act [750 ILCS 22];

E) The Illinois Parentage Act of 1984 [750 ILCS 45]; and

F) Any other statute in another state which provides for child support.

4) "Retroactive support" means support for a period prior to the date a court or administrative support order is entered.

5) "Child's needs" means the cost of raising a child as detailed by either:

A) the custodial parent's statement of the associated costs, including, but not limited to, providing a child with: food, shelter, clothing, schooling, recreation, transportation and medical care; or

B) the Department's standard for the costs of raising a child taking into account average actual costs of providing a child with: food, shelter, clothing, schooling, recreation, transportation and medical care in a manner consistent with health and well being as set forth in this Part.

b) Responsible Relative Contact

1) Timing and Purpose of Contact

A) The Department shall contact and interview responsible relatives in Title IV-D cases to establish support obligations, following the IV-D client interview.

B) The purpose of contact and interview shall be to obtain relevant facts, including income information (for example, paycheck stubs, income tax returns) necessary to determine the financial ability of such relatives for use in obtaining stipulated, consent and other court orders for support and in entering administrative support orders, pursuant to the support statutes.

2) At least ten working days in advance of the interview, the Department
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shall notify each responsible relative contacted of his support obligation, by ordinary mail, which notice shall contain the following:

A) the Title IV-D case name and identification number;

B) the names and birthdates of the persons for whom support is sought or other information identifying such persons, such as a prior court number;

C) that the responsible relative has a legal obligation to support the named persons;

D) the date, time, place and purpose of the interview and that the responsible relative may be represented by counsel; and

E) that the responsible relative should bring specified information regarding his income and resources to the interview.

3) The Department shall notify each Title IV-D client of the date, time and place of the responsible relative interview and that the client may attend if he or she chooses.

c) Determination of Financial Ability

1) In cases handled under subsection (d) of this Section, the Family Support Specialist shall determine the amount of child support and enter an administrative support order on the following basis:

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Percent of Responsible Relative's Net Income</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>20%</td>
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<tr>
<td>2</td>
<td>28%25%</td>
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<tr>
<td>3</td>
<td>32%</td>
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<td>4</td>
<td>40%</td>
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<td>45%</td>
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<td>6 or more</td>
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</tbody>
</table>

A) "Net Income" is the total of all income from all sources, minus the following deductions:
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i) Federal income tax (properly calculated withholding or estimated payments);

ii) State income tax (properly calculated withholding or estimated payments);

iii) Social Security (FICA payments);

iv) Mandatory retirement contributions required by law or as a condition of employment;

v) Union dues;

vi) Dependent and individual health/hospitalization insurance premiums;

vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;

viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;

ix) Medical expenditures necessary to preserve life or health; and

x) Reasonable expenditures for the benefit of the child and the other parent, exclusive of gifts.

B) The deductions in subsections (c)(1)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders which contain provisions for an automatic increase in the support obligation upon termination of such payment period.

2) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall determine the minimum amount of child support as follows:

| Number of | Percent of Responsible |
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<table>
<thead>
<tr>
<th>Children</th>
<th>Relative's Net Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>2</td>
<td>28%</td>
</tr>
<tr>
<td>3</td>
<td>32%</td>
</tr>
<tr>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>5</td>
<td>45%</td>
</tr>
<tr>
<td>6 or more</td>
<td>50%</td>
</tr>
</tbody>
</table>

A) "Net Income" is the total of all income from all sources, minus the following deductions:

i) Federal income tax (properly calculated withholding or estimated payments);

ii) State income tax (properly calculated withholding or estimated payments);

iii) Social Security (FICA payments);

iv) Mandatory retirement contributions required by law or as a condition of employment;

v) Union dues;

vi) Dependent and individual health/hospitalization insurance premiums;

vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;

viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;

ix) Medical expenditures necessary to preserve life or health; and

x) Reasonable expenditures for the benefit of the child and the other parent, exclusive of gifts.
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B) The deductions in subsections (c)(2)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders that contain provisions for an automatic increase in the support obligation upon termination of such payment period.

C) The above guidelines shall be applied in each case unless the Department finds that application of the guidelines would be inappropriate after considering the best interests of the child in light of evidence including but not limited to one or more of the following relevant factors:

i) the financial resources and needs of the child;

ii) the financial resources and needs of the custodial parent;

iii) the standard of living the child would have enjoyed had the marriage not been dissolved, the separation not occurred or the parties married;

iv) the physical and emotional condition of the child, and his educational needs; and

v) the financial resources and needs of the non-custodial parent.

D) Each order requiring support that deviates from the guidelines shall state the amount of support that would have been required under the guidelines. The reason or reasons for the variance from the guidelines shall be included in the order.

3) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the amount of child support due in accord with Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505].

4) All orders for support shall include a provision for the health care coverage of the child. In all cases where health insurance coverage is not being furnished by the responsible relative to a child to be covered by a support order, the Department shall enter administrative, or request the
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court to enter support orders, requiring the relative to provide such coverage when a child can be added to an existing insurance policy at reasonable cost or indicating what alternative arrangement for health insurance coverage is being provided. Net income shall be reduced by the cost thereof in determining the minimum amount of support to be ordered.

5) When proceeding under subsection (d) of this Section, the Department shall, in any event, notwithstanding other provisions of this subsection (c) and regardless of the amount of the responsible relative's net income, order the responsible relative to pay child support of at least $10.00 per month.

6) In cases where the net income of the responsible relative cannot be determined because of default or any other reason, the Department shall order or request the court to order the responsible relative to pay retroactive support for the prior period in the amount of the child's needs as defined by subsection (a)(5)(A) or (B) of this Section.

7) The final order in all cases shall state the support level in dollar amounts.

8) If there is no net income because of the unemployment of a responsible relative who resides in Illinois and is not receiving General Assistance in the City of Chicago and has children receiving cash assistance in Illinois, the Department, when proceeding under subsection (d) of this Section, shall order, or, when proceeding under subsection (e) of this Section, shall request the court to order the relative to report for participation in job search, training or work programs established for such relatives. In TANF cases, the Department shall order, when proceeding under subsection (d) of this Section, or, when proceeding under subsection (e) of this Section, shall request the court to order payment of past-due support pursuant to a plan and, if the responsible relative is unemployed, subject to a payment plan and not incapacitated, that the responsible relative participate in job search, training and work programs established under Section 9-6 and Article Ixa of the Illinois Public Aid Code [305 ILCS 5/9-6 and Art. Ixa].

9) The Department shall enter administrative support orders, or request the court to enter support orders, that include a provision requiring the responsible relative to notify the Department, within seven days:
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A) of any new address of the responsible relative;

B) of the name and address of any new employer or source of income of the responsible relative;

C) of any change in the responsible relative's Social Security Number;

D) whether the responsible relative has access to health insurance coverage through the employer or other group coverage; and

E) if so, the policy name and number and the names of persons covered under the policy.

10) The Department shall enter administrative support orders, or request the court to enter support orders, that include a date on which the current support obligation terminates. The termination date shall be no earlier than the date on which the child covered by the order will attain the age of majority or is otherwise emancipated. The order for support shall state that the termination date does not apply to any arrearage that may remain unpaid on that date. The provision of a termination date in the order shall not prevent the order from being modified.

11) The Department shall enter administrative support orders, or request the court to enter support orders, that include provisions for retroactive support when appropriate.

A) In cases handled under subsection (d) of this Section, the Department shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties' separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock).

B) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties' separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock), unless, in cases where the child was
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born out of wedlock, the hearing officer, after having examined the factors set forth in Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505] decides that another date is more appropriate.

C) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the date retroactive support is to commence in accord with Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X], Sections 510 and 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/510 and 505], and Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14].

d) Administrative Process

1) Use of Administrative Process

A) Unless otherwise directed by the Department, the FSS shall establish support obligations of responsible relatives through the administrative process set forth in this subsection (d), in Title IV-D cases, wherein the court has not acquired jurisdiction previously, in matters involving:

i) presumed paternity as set forth in Section 5 of the Illinois Parentage Act of 1984 [750 ILCS 45/5] and support is sought from one or both parents;

ii) alleged paternity and support is sought from the mother;

iii) an administrative paternity order entered under Section 160.61 and support is sought from the man determined to be the child's father, or from the mother, or both;

iv) an establishment of parentage in accordance with Section 6 of the Illinois Parentage Act of 1984 [750 ILCS 45/6]; and

v) an establishment of parentage under the laws of another state, and support is sought from the child's father, or from the mother, or both.
B) In addition to those items specified in subsection (b)(2) of this Section, the notice of support obligation shall inform the responsible relative of the following:

i) that the responsible relative may be required to pay retroactive support as well as current support; and

ii) that in its initial determination of child support under subsection (c) of this Section, the Department will only consider factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and

iii) that the Department will enter an administrative support order based only on those factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and

iv) that in order for the Department to consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and

v) that both the client and the responsible relative have a right to request a de novo hearing within 30 days after the mailing or delivery of an administrative support order, at which time a Department hearing officer may consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505]; and

vi) that unless the client and/or the responsible relative requests a de novo hearing within 30 days after the order's mailing or delivery, the administrative support order will become a final enforceable order of the Department; and
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vii) that upon failure of the responsible relative to appear for the interview or to provide necessary information to determine net income, an administrative support order may be entered by default or the Department may seek court determination of financial ability based upon the guidelines.

2) The FSS shall determine the ability of each responsible relative to provide support in accordance with subsection (c) of this Section when such relative appears in response to the notice of support obligation and provides necessary information to determine net income. An administrative support order shall be entered which shall incorporate the resulting support amount therein. The FSS shall also determine (and incorporate in the administrative support order) the amount of retroactive support the responsible relative shall be required to pay by applying the relative's current net income (unless the relative provides necessary information to determine net income for the prior period) to the support guidelines in accordance with subsection (c) of this Section.

3) Failure to Appear

A) In instances in which the responsible relative fails to appear in response to the notice of support obligation or fails to provide necessary information to determine net income, the FSS shall enter an administrative support order by default, except as provided in subsection (d)(3)(D) of this Section. The terms of the order shall be based upon the needs of the child for whom support is sought, as defined by subsection (a)(5) of this Section. No default order shall be entered when a responsible relative fails to appear at the interview unless the relative shall have been served as provided by law with a notice of support obligation.

B) The FSS may issue a subpoena to a responsible relative who fails to appear for interview, or who appears and furnishes income information, when the FSS has information from the Title IV-D client, the relative's employer or any other reliable source indicating that:

i) financial ability, as determined from the guidelines contained in subsection (c) of this Section, exceeds the
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amount indicated in case of default, as indicated in subsection (d)(3)(A) of this Section; or

ii) income exceeds that reported by the relative.

C) The FSS will not issue a subpoena under subsection (d)(3)(B) of this Section where the information from the Title IV-D client, the responsible relative's employer or other source concerning the relative's financial ability is verified through documentation such as payroll records, paycheck stubs or income tax returns.

D) In instances in which the relative fails or refuses to accept or fully respond to a Department subpoena issued to him pursuant to subsection (d)(3)(B) of this Section, the FSS may enter a temporary administrative support order by default, in accordance with subsection (d)(3)(A) of this Section, and may then, after investigation and determination of the responsible relative's financial ability to support, utilizing existing State and federal sources (for example, Illinois Department of Employment Security), client statements, employer statements, or the use of the Department's subpoena powers, enter a support order in accord with subsection (c)(1) of this Section.

4) The Department shall register, enforce or modify an order entered by a court or administrative body of another state, and make determinations of controlling order where appropriate, in accordance with the provisions of the Uniform Interstate Family Support Act [750 ILCS 22].

5) An administrative support order shall include the following:

A) the Title IV-D case name and identification number;

B) the names and birthdates of the persons for whom support is ordered;

C) the beginning date, amount and frequency of support;

D) any provision for health insurance coverage ordered under subsection (c)(4) of this Section;
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E) the total retroactive support obligation and the beginning date, amount (which shall not be less than 20 percent of the current support amount) and frequency of payments to be made until the retroactive support obligation is paid in full;

F) the amount of any arrearage that has accrued under a prior support order and the beginning date, amount (which shall not be less than 20 percent of the support order) and frequency of payments to be made until the arrearage is paid in full;

G) a provision requiring that support payments be made to the State Disbursement Unit;

H) a statement informing the client and the responsible relative that they have 30 days from the date of mailing of the administrative support order in which to petition the Department for a release from or modification of the order and receive a hearing in accordance with 89 Ill. Adm. Code 104.102 and subsection (c)(2) of this Section, except that for orders entered as a result of a decision after a de novo hearing, the statement shall inform the client and the responsible relative that the order is a final administrative decision of the Department and that review is available only in accord with provisions of the Administrative Review Law [735 ILCS 5/Art. III];

I) except where the order was entered as a result of a decision after a de novo hearing, a statement that the order was based upon the factors listed in subsection (c)(1)(A) of this Section and that in order to have the Department consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and

J) in each administrative support order entered or modified on or after January 1, 2002, a statement that a support obligation required under the order, or any portion of a support obligation required under the order, that becomes due and remains unpaid for 30 days
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or more shall accrue simple interest at the rate of nine percent per annum.

6) Every administrative support order entered on or after July 1, 1997, shall include income withholding provisions based upon and containing the same information as prescribed in Section 160.75. The Department shall also prepare and serve income withholding notices after entry of an administrative support order and effect income withholding in the same manner as prescribed in Section 160.75.

7) The Department shall provide to each client and each responsible relative a copy of each administrative support order entered, no later than 14 days after entry of such order, by:

A) delivery at the conclusion of an interview where financial ability to support was determined. An acknowledgment of receipt signed by the client or relative or an affidavit of delivery signed by the Department's representative shall be sufficient for purposes of notice to that person.

B) regular mail to the party not receiving personal delivery where the relative fails or refuses to accept delivery, where either party does not attend the interview, or the orders are entered by default.

8) In any case where the administrative support process has been initiated for the custodial parent and the non-marital child, and the custodial parent and the non-marital child move outside the original county, the administrative support case shall remain in the original county unless a transfer to the other county in which the custodial parent and the non-marital child reside is requested by either party or the Department and the hearing officer assigned to the original county finds that a change of venue would be equitable and not unduly hamper the administrative support process.

9) In any case in which an administrative support order is entered to establish and enforce an arrearage only, and the responsible relative's current support obligation has been terminated, the administrative support order shall require the responsible relative to pay a periodic amount equal to the terminated current support amount until the arrearage is paid in full.

e) Judicial Process
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1) The Department shall refer Title IV-D cases for court action to establish support obligations of responsible relatives, pursuant to the support statutes (see subsection (a)(3) of this Section) in matters requiring the determination of parentage (except when paternity is to be determined administratively under Section 160.61), when the court has acquired jurisdiction previously and in instances described in subsection (d)(3)(D) of this Section, and as otherwise determined by the Department.

2) The Department shall prepare and transmit pleadings and obtain or affix appropriate signature thereto, which pleadings shall include, but not be limited to, petitions to:

A) intervene;
B) modify;
C) change payment path;
D) establish an order for support;
E) establish retroactive support;
F) establish past-due support;
G) establish parentage;
H) obtain a rule to show cause;
I) enforce judicial and administrative support orders; and
J) combinations of the above.

3) Department legal representatives shall request that judicial orders for support require payments to be made to the State Disbursement Unit in accordance with Section 10-10.4 of the Illinois Public Aid Code [305 ILCS 5/10-10.4], Section 507.1 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/507.1], Section 320 of the Uniform Interstate Family Support Act [750 ILCS 22/320], Section 21.1 of the Illinois Parentage Act of 1984 [750 ILCS 45/21.1] and Section 25 of the Non-
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Support Punishment Act [750 ILCS 16/25].

(Source: Amended at 27 Ill. Reg. 18899, effective November 26, 2003)
DEPARTMENT OF REVENUE

NOTICE OF EMERGENCY AMENDMENT

1) **Heading of the Part:** Retailers’ Occupation Tax

2) **Code Citation:** 86 Ill. Adm. Code 130

3) **Section Numbers:** 130.552

4) **Emergency Action:** New Section

5) **Effective Date of Emergency Amendment:** November 26, 2003

6) **If this Emergency Amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire:** This rule will not expire before the end of the 150 day period.

7) **Date filed with the Index Department:** November 26, 2003

8) **Reason for Emergency:** P.A. 93-0022 requires that certain liquor retailers begin reporting purchases of alcoholic liquor to the Department beginning on October 1, 2003. A threat to the public’s interest exists due to the under reporting of sales tax revenue by a number of liquor retailers. The reporting of purchases of alcoholic liquor by liquor retailers will be compared by the Department to sales for the same periods by such liquor retailers and is anticipated to lessen the under reporting of sales tax revenue.

9) **A Complete Description of the Subjects and Issues Involved:** This emergency rulemaking implements the requirements of P.A. 93-0022 that require purchases of alcoholic liquor to be reported to the Department by liquor retailers and liquor wholesalers beginning on October 1, 2003. This emergency rulemaking requires liquor stores, taverns, and restaurants that serve alcoholic beverages to report liquor purchases for each month on their ST-1, Sales and Use Tax Return, and to file such returns using the Department’s TeleFile system. Such reporting requirements do not apply to taxpayers that make quarter-monthly sales tax payments or wholesalers or manufacturers of alcoholic liquors. This emergency rulemaking also requires wholesalers and manufacturers of alcoholic liquor to electronically file a statement with the Department on the 10th day of each month showing the total amount of gross receipts from alcoholic liquors sold or distributed to purchasers in the preceding month. As an alternative, the rules allow such wholesalers and manufacturers of alcoholic liquor to electronically file
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the statement in conjunction with their electronically filed Form RL-26, Liquor Revenue Return, no later than the 15th day of the month. Wholesalers and manufacturers of alcoholic liquor are also required to provide liquor stores, taverns, and restaurants with a copy of such statement by the 10th day of each month. However, the rules allow such wholesalers and manufacturers of alcoholic liquor to provide a cumulative total of sales to each retailer on the invoices provided to each retailer in lieu of providing the statement to those retailers.

11) Are there any proposed amendments to this Part pending? No

12) Statement of Statewide Policy Objectives: This rulemaking neither imposes a State mandate, nor modifies an existing mandate.

13) Information and questions regarding this Emergency Amendment shall be directed to:

Terry D. Charlton
Associate Counsel
Illinois Department of Revenue
101 West Jefferson
Springfield, Illinois 62794
Phone: (217) 782-2844

The full text of the emergency amendment begins on the next page:

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CHAPTER I: DEPARTMENT OF REVENUE

PART 130
RETAILERS' OCCUPATION TAX

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<td>130.120</td>
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130.2500 Direct Payment Program
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130.ILLUSTRATION A Examples of Tax Exemption Card


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SUBPART E: RETURNS

Section 130.552  Alcoholic Liquor Reporting

EMERGENCY

a) Retailer Liquor Report. Beginning on October 1, 2003, any person that is engaged in the business of selling alcoholic liquor at retail through a liquor store, tavern, or restaurant shall file a monthly statement with the Department listing the total amount paid for alcoholic liquor purchased during the preceding calendar month. The statement shall be filed on such person’s Form ST-1, Sales and Use Tax Return, by including the total amount shown on invoices for alcoholic liquor delivered during the preceding calendar month. Such Form ST-1 Return shall be filed using the Department’s TeleFile program (86 Ill. Adm. Code 770). The requirements of this subsection (a) shall not apply to any person who is a licensed distributor, importing distributor, or manufacturer as those persons are described in Sections 1-3.08, 1-3.15, and 1-3.16 of the Liquor Control Act of 1934. The requirements of this subsection (a) shall not apply to any person who is required to make quarter monthly payments on the 7th, 15th, 22nd, and last day of each month under Section 3 of the Retailers' Occupation Tax Act. [35 ILCS 120/3]

For purposes of this subsection (a):

1) “Liquor store” means any legal entity that is operated primarily to sell alcoholic liquor at retail to the public. To meet the primary test, the selling price of all the alcoholic liquor sold during a calendar year must exceed 50% of the selling price of all retail sales for that calendar year.
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2) “Tavern” means any legal entity that is operated to sell alcoholic liquor at retail to the public for on-premises consumption.

3) “Restaurant” means any legal entity that is operated to sell food and alcoholic liquor at retail to the public for on-premises consumption.

b) Distributor Liquor Report. Beginning on October 1, 2003, every distributor, importing distributor, and manufacturer of alcoholic liquor, as those persons are described in Sections 1-3.08, 1-3.15, and 1-3.16 of the Liquor Control Act of 1934, shall file, in an electronic format prescribed by the Department, a statement with the Department of Revenue, no later than the 10th day of the month for the preceding month during which transactions occurred showing the total amount of gross receipts from the sale of alcoholic liquor sold or distributed during the preceding calendar month to purchasers; identifying the purchaser to whom it was sold or distributed; the purchaser’s tax registration number; and such other information reasonably required by the Department. A copy of the monthly statement shall be provided to the retailer no later than the 10th day of the month for the preceding calendar month during which such transactions occurred. In lieu of such a statement, a distributor, importing distributor, or manufacturer of alcoholic liquor may list a cumulative total of that distributor’s, importing distributor’s, and manufacturer of alcoholic liquor’s total sales of alcoholic liquor to a retailer within that current calendar month on all invoices provided to that retailer. The statement required to be filed with the Department under this subsection (b) shall be filed no later than the 10th day of the month for the preceding calendar month in an electronic format prescribed by the Department. If the distributor, importing distributor, or manufacturer files its Form RL-26, Liquor Revenue Return, electronically, the statement required to be filed under this subsection (b) may be filed in conjunction with the electronic filing of the Liquor Revenue Return no later than the 15th day of the month for the preceding calendar month. [35 ILCS 120/3]

(Source: Added by emergency rulemaking at 27 Ill. Reg. 18911, effective November 26, 2003, for a maximum of 150 days)
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1) **Heading of the Part**: TeleFile Program

2) **Code Citation**: 86 Ill. Adm. Code 770

3) **Section Numbers**:

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<td>770.130</td>
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4) **Statutory Authority**: P.A. 93-0022

5) **Effective Date of Emergency Amendment**: November 26, 2003

6) If this Emergency Amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: This rulemaking will not expire before the end of the 150 day period.

7) **Date filed with the Index Department**: November 26, 2003

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

9) **Reason for Emergency**: P.A. 93-0022 requires that liquor retailers begin reporting purchases of alcoholic liquor to the Department beginning on October 1, 2003. A threat to the public’s interest exists due to the under-reporting of sales tax revenue by a number of liquor retailers. The reporting of purchases of alcoholic liquor by liquor retailers will be compared by the Department to sales for the same periods by such liquor retailers and is anticipated to lessen the under-reporting of sales tax revenue. The reporting of the purchases of alcoholic liquor by liquor retailers will be made by listing such amounts on the retailer’s ST-1 Sales and Use Tax Return which will be filed using the Department’s TeleFile system under this emergency rulemaking.

11) **A Complete Description of the Subjects and Issues Involved**: This emergency rulemaking implements the provisions of P.A. 93-0022 that require purchases of alcoholic liquor to be reported to the Department by liquor retailers and liquor wholesalers beginning on October 1, 2003. P.A. 93-0022 provides that the Department may adopt rules to require that such reporting by done in an electronic or telephonic
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format. New Section 130.552 of Part 130 requires that the statement of such liquor purchases be reported for each month on the retailer’s ST-1, Sales and Use Tax Return. This emergency rulemaking requires that liquor retailers file such returns using the Department’s TeleFile system.

11) Are there any proposed amendments to this Part pending? No

12) Statement of Statewide Policy Objectives: This rulemaking neither imposes a State mandate, nor modifies an existing mandate.

14) Information and questions regarding this Emergency Amendment shall be directed to:

   Terry D. Charlton
   Associate Counsel
   Illinois Department of Revenue
   101 West Jefferson
   Springfield, Illinois 62794
   Phone: (217) 782-2844

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

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 770
VOLUNTARY TELEFILE PROGRAM

Section
770.100 Voluntary TeleFile Program
EMERGENCY
770.105 Mandatory TeleFile Program
EMERGENCY
770.110 Exclusions from TeleFile
EMERGENCY
770.120 How to Participate
EMERGENCY
770.130 Personal Identification Number (PIN)
EMERGENCY
770.140 Confirmation Numbers
770.150 Due Dates and Date Received
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AUTHORITY: Implementing and authorized by Section 39c-1a of the Civil Administrative Code of Illinois [20 ILCS 2505/39c-1a].

SOURCE: Adopted at 24 Ill. Reg. 8384, effective June 2, 2000; emergency amendment at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days.

Section 770.100 Voluntary TeleFile Program

EMERGENCY

a) The Department has created a voluntary TeleFile program for certain tax returns. The Department will notify potential participants that they may voluntarily participate in the TeleFile program and TeleFile any of the returns listed in subsection (c) of this Section.

b) "TeleFile" consists of a taxpayer using a touch-tone telephone to call a telephone number provided by the Department and reporting return information through the use of the number keys on the touch-tone telephone in response to an automated voice prompt system.

c) The following type of return may be filed through the use of this voluntary TeleFile program: Form ST-1 Sales and Use Tax Return.

d) The Department reserves the right to limit the number of participants in this TeleFile program if the level of participation either exceeds or is expected to exceed the Department's resources available for the program.

e) Requirements for participation in the voluntary Telefile program:

1) The taxpayer must have on file with the Department of Revenue a properly completed Form NUC-1 Illinois Business Registration with an individual listed as the person responsible for the filing of the returns and the payment of taxes due;

2) The taxpayer must be a single-site filer (has only one Illinois location from which retail sales are made); and

3) The taxpayer must not be required to make quarterly monthly payments under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act, or the Service Use Tax Act.
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(Source: Amended by emergency rulemaking at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days)

Section 770.105  Mandatory TeleFile Program

EMERGENCY

a) The Department has created a Mandatory TeleFile program for certain tax returns. The Department will notify participants that they must participate in the Mandatory TeleFile program and TeleFile the returns listed in subsection (c) of this Section.

b) "TeleFile" consists of a taxpayer using a touch-tone telephone to call a telephone number provided by the Department and reporting return information through the use of the number keys on the touch-tone telephone in response to an automated voice prompt system.

c) The following type of return must be filed through the use of this mandatory TeleFile program: Form ST-1 Sales and Use Tax Returns filed by liquor retailers that are required to provide a statement of the total amount of alcoholic liquor purchased by that liquor retailer during the previous month as required by 86 Ill. Adm. Code 130.552.

d) Returns from taxpayers who are required to make quarter monthly payments under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act, or the Service Use Tax Act are excluded from this mandatory TeleFile program.

e) Taxpayers who are filing the returns listed in subsection (c) of this Section by means of the Department’s electronic filing program under Part 760 are excluded from this mandatory TeleFile program for the period in which they are filing those returns under the provisions of Part 760. See 86 Ill. Adm. Code Part 760.

(Source: Added by emergency rulemaking at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days)

Section 770.110  Exclusions from TeleFile

EMERGENCY

The following types of returns are excluded from this TeleFile program:

a) Returns that are not listed in subsection (c) of Section 770.100 of this Part of
DEPARTMENT OF REVENUE

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subsection (c) of Section 770.105 of this Part.

b) Returns listed in subsection (c) of Section 770.100 of this Part or returns listed in subsection (c) of Section 770.105 of this Part that require additional forms or schedules, or that require the reporting of information that the Department is unable to currently accept through the TeleFile program.

(Source: Amended by emergency rulemaking at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days)

Section 770.120 How to Participate

EMERGENCY

a) Taxpayers whose participation is voluntary will receive the necessary information packet from the Department as they become eligible to file the returns listed in subsection (c) of Section 770.100 of this Part. Taxpayers whose participation is mandatory will be notified by the Department that they are required to file the returns listed in subsection (c) of Section 770.105 of this Part, and will also receive the necessary information packet. Participants must call the telephone number in the information packet provided. After receiving the necessary information packet from the Department, participants must call the telephone number provided to potential participants.

b) Participants must enter their Illinois Business Tax number (IBT number) and a Personal Identification Number (PIN) issued by the Department that will allow them access to the TeleFile system.

c) Participants will enter their information in accordance with the TeleFile instruction sheet provided by the Department through the use of the number keys on a touch-tone telephone in response to an automated voice prompt system.

d) At the end of a successfully completed TeleFile filing, the automated voice prompt system will confirm the return has been filed with the Department by issuing a confirmation number as provided in Section 770.140 of this Part.

e) Any balance due on a return filed through the use of TeleFile must be paid by the due date in the same manner as if the return was filed in a paper format. For example, a check for the proper amount due may be mailed to the Department or payment may be made through the use of electronic funds transfer (see 86 Ill. Adm. Code 750).
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f) Participants using the TeleFile system cannot recall or intercept a return that has been filed using the TeleFile system after that return has been confirmed as received. Participants wishing to make any changes to a return that has been filed using the TeleFile system must file an amended return in a paper format.

(Source: Amended by emergency rulemaking at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days)

Section 770.130 Personal Identification Number (PIN)

a) Potential voluntary participants that have listed an individual and provided that individual's signature on the taxpayer's registration form as being responsible for the filing of returns and payment of the tax for that taxpayer may be issued a PIN by the Department.

b) The PIN issued by the Department, when utilized by the participant in combination with the participant's IBT number, will be used as the responsible person's electronic signature on the return that is filed through use of the TeleFile program. The use of the PIN in combination with the IBT number has the same legal effect as if the taxpayer had signed the return that is a part of that TeleFile filing.

1) For returns listed in subsection (c) of Section 770.105 of this Part that are required to be filed through the TeleFile program and that are filed by a corporate taxpayer whose registration does not list an individual as being responsible for the filing of returns and payment of the tax for that taxpayer, the use of the PIN in combination with the IBT number has the same legal effect as if the President of that corporation had signed the return that is part of that TeleFiling. Until such time as another person is identified by the corporation as being the person responsible for the filing of returns and payment of the tax, the President of the corporation is deemed to be the responsible party.

2) For returns listed in subsection (c) of Section 770.105 of this Part that are required to be filed through the TeleFile program and that are filed by a partnership whose registration does not list an individual as being responsible for the filing of returns and payment of the tax for that partnership, the use of the PIN in combination with the IBT number has
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the same legal effect as if the partners of that partnership had signed the return that is part of that TeleFiling. Until such time as another person is identified by the partnership as being the person responsible for the filing of returns and payment of the tax, the partners of that partnership are deemed to be the responsible parties.

c) Participants are responsible for notifying the Department when the person listed and whose signature appears on the Department's records as being responsible for the filing of returns and payment of the tax for that taxpayer no longer has that responsibility or authority on behalf of the taxpayer. Upon such notification, the Department will void that PIN. When the Department receives the necessary information regarding the person who is responsible for the filing of returns and payment of the tax for that taxpayer, the Department will issue a new PIN to that participant.

d) The participant is responsible for the security and safekeeping of the PIN. Participants must notify the Department if the security of the PIN has been compromised or a new responsible person has been appointed as required in subsection (c) of this Section. Upon such notification, the Department will void that PIN and a new PIN will be issued.

(Source: Amended by emergency rulemaking at 27 Ill. Reg. 18924, effective November 26, 2003, for a maximum of 150 days)
JOINT COMMITTEE ON ADMINISTRATIVE RULES
DECEMBER AGENDA

SCHEDULED MEETING:

JAMES THOMPSON CENTER
ROOM 16-503
CHICAGO, ILLINOIS
10:30 A.M.
DECEMBER 16, 2003

NOTICES: The scheduled date and time for the JCAR meeting are subject to change. Due to Register submittal deadlines, the Agenda below may be incomplete. Other items not contained in this published Agenda are likely to be considered by the Committee at the meeting and items from the list can be postponed to future meetings.

If members of the public wish to express their views with respect to a rulemaking, they should submit written comments to the Office of the Joint Committee on Administrative Rules at the following address:

Joint Committee on Administrative Rules
700 Stratton Office Building
Springfield, Illinois 62706
Email: jcar@legis.state.il.us
Phone: 217/785-2254

RULEMAKINGS CURRENTLY BEFORE JCAR

PROPOSED RULEMAKINGS

Banks and Real Estate

1. Minimum Organizational Capital Requirements for Banks and Trust Companies (38 Ill. Adm. Code 310)
   - First Notice Published: 27 Ill. Reg. 14920 – 9/26/03
   - Expiration of Second Notice: 12/26/03

2. Electronic Fund Transfers (38 Ill. Adm. Code 315)
   - First Notice Published: 27 Ill. Reg. 14927 – 9/26/03
   - Expiration of Second Notice: 12/27/03
JOINT COMMITTEE ON ADMINISTRATIVE RULES
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   -First Notice Published: 27 Ill. Reg. 14936 – 9/26/03
   -Expiration of Second Notice: 12/26/03

4. Pledging Requirements for Illinois Trust Companies (38 Ill. Adm. Code 398)
   -First Notice Published: 27 Ill. Reg. 14945 – 9/26/03
   -Expiration of Second Notice: 12/27/03

   -First Notice Published: 27 Ill. Reg. 10626 – 7/18/03
   -Expiration of Second Notice: 12/18/03

6. Real Estate Appraiser Licensing (68 Ill. Adm. Code 1455)
   -First Notice Published: 27 Ill. Reg. 15212 – 10/3/03
   -Expiration of Second Notice: 1/3/04

Central Management Services

7. Local Government Health Plan (80 Ill. Adm. Code 2160)
   -First Notice Published: 27 Ill. Reg. 6 – 1/3/03
   -Expiration of Second Notice: 1/3/04

Children and Family Services

8. Facilities and Programs Exempt From Licensure (89 Ill. Adm. Code 377)
   -First Notice Published: 27 Ill. Reg. 2755 – 2/21/03
   -Expiration of Second Notice: 1/7/04

   -First Notice Published: 27 Ill. Reg. 2765 – 2/21/03
   -Expiration of Second Notice: 1/7/04

Insurance

    -First Notice Published: 27 Ill. Reg. 6563 – 4/18/03
    -Expiration of Second Notice: 12/18/03
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Natural Resources

11. Dog Training on Department-Owned or -Managed Sites (17 Ill. Adm. Code 950)
    -First Notice Published: 27 Ill. Reg. 14759 – 9/19/03
    -Expiration of Second Notice: 12/20/03

Pollution Control Board

    -First Notice Published: 27 Ill. Reg. 11879 – 7/25/03
    -Expiration of Second Notice: 12/26/03

Public Health

    -First Notice Published: 27 Ill. Reg. 14147 – 8/29/03
    -Expiration of Second Notice: 12/27/03

Racing Board

    -First Notice Published: 27 Ill. Reg. 9106 – 6/13/03
    -Expiration of Second Notice: 12/26/03

Revenue

15. Income Tax (86 Ill. Adm. Code 100)
    -First Notice Published: 27 Ill. Reg. 13754 – 8/15/03
    -Expiration of Second Notice: 1/8/04

    -First Notice Published: 27 Ill. Reg. 15064 – 9/26/03
    -Expiration of Second Notice: 12/31/03

17. Aircraft Use Tax (86 Ill. Adm. Code 152)
    -First Notice Published: 27 Ill. Reg. 10195 – 7/11/03
    -Expiration of Second Notice: 1/7/04

    -First Notice Published: 27 Ill. Reg. 10197 – 7/11/03
    -Expiration of Second Notice: 12/31/03
   -First Notice Published: 27 Ill. Reg. 10199 – 7/11/03
   -Expiration of Second Notice: 1/3/04

   -First Notice Published: 27 Ill. Reg. 10201 – 7/11/03
   -Expiration of Second Notice: 12/31/03

   -First Notice Published: 27 Ill. Reg. 10203 – 7/11/03
   -Expiration of Second Notice: 12/31/03

22. Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act (86 Ill. Adm. Code 530)
   -First Notice Published: 27 Ill. Reg. 15758 – 10/10/03
   -Expiration of Second Notice: 1/7/04

State Fire Marshal

23. Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120)
   -First Notice Published: 27 Ill. Reg. 15022 – 9/26/03
   -Expiration of Second Notice: 12/26/03

Student Assistance Commission

24. Illinois Future Teacher Corps (IFTC) Program (23 Ill. Adm. Code 2764)
   -First Notice Published: 27 Ill. Reg. 14797 – 9/19/03
   -Expiration of Second Notice: 1/4/04

Transportation

   -First Notice Published: 27 Ill. Reg. 15077 – 9/26/03
   -Expiration of Second Notice: 12/26/03

   -First Notice Published: 27 Ill. Reg. 15083 – 9/26/03
   -Expiration of Second Notice: 12/26/03
JOINT COMMITTEE ON ADMINISTRATIVE RULES
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27. Hours of Service of Drivers (92 Ill. Adm. Code 395)
   -First Notice Published: 27 Ill. Reg. 15088 – 9/26/03
   -Expiration of Second Notice: 12/26/03

EMERGENCY RULEMAKINGS

   Commerce and Economic Opportunity

   -Notice Published: 27 Ill. Reg. 17400 – 11/21/03

   Human Services

29. Determination of Need (DON) and Resulting Service Cost Maximums (SCMs) (89 Ill.
    Adm. Code 679)
   -Notice Published: 27 Ill. Reg. 17428 – 11/21/03

   Natural Resources

    -Notice Published: 27 Ill. Reg. 17270 – 11/14/03

   Revenue

    -Notice Published: 27 Ill. Reg. 17094 – 11/7/03

   Secretary of State

32. Issuance of Licenses (92 Ill. Adm. Code 1030)
    -First Notice Published: 27 Ill. Reg. 16968 – 10/31/03

   State Toll Highway Authority

33. State Toll Highway Authority (92 Ill. Adm. Code 2520)
    -Notice Published: 27 Ill. Reg. 18238 – 12/1/03
PEREMPTORY RULEMAKINGS

Agriculture

34. Meat and Poultry Inspection Act (8 Ill. Adm. Code 125)
   -Notice Published: 27 Ill. Reg. 17281 – 11/14/03

   -Notice Published: 27 Ill. Reg. 18270 – 12/1/03

Central Management Services

36. Pay Plan (80 Ill. Adm. Code 310)
   -Notice Published: 27 Ill. Reg. 17433 – 11/21/03

AGENCY RESPONSES

Banks and Real Estate


SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of November 24, 2003 through December 1, 2003 and have been scheduled for review by the Committee at its December 16, 2003 meeting in Chicago. 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.

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<td>Subscription to the Illinois Register (52 Issues)</td>
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<td>Cumulative/Sections Affected Indices 1990 - 2002</td>
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(Processing fee for credit cards purchases, if applicable.) $ 1.50

**TOTAL AMOUNT OF ORDER** $

- **Check**
- **Make Checks Payable To:** Secretary of State
- **VISA**
- **Master Card**
- **Discover**  (There is a $1.50 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) 524-0308

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