

# 2011

# ILLINOIS

# REGISTER

RULES  
OF GOVERNMENTAL  
AGENCIES



Index Department  
Administrative Code Division  
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May 13, 2011 Volume 35, Issue 20

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## INTRODUCTION

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

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

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

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

### ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2011

<u>Issue #</u>	<u>Rules Due Date</u>	<u>Date of Issue</u>
1	December 20, 2010	January 3, 2011
2	December 27, 2010	January 7, 2011
3	January 3, 2011	January 14, 2011
4	January 10, 2011	January 21, 2011
5	January 18, 2011	January 28, 2011
6	January 24, 2011	February 4, 2011
7	January 31, 2011	February 14, 2011
8	February 7, 2011	February 18, 2011
9	February 15, 2011	February 25, 2011
10	February 22, 2011	March 4, 2011
11	February 28, 2011	March 11, 2011
12	March 7, 2011	March 18, 2011
13	March 14, 2011	March 25, 2011
14	March 21, 2011	April 1, 2011
15	March 28, 2011	April 8, 2011
16	April 4, 2011	April 15, 2011
17	April 11, 2011	April 22, 2011
18	April 18, 2011	April 29, 2011
19	April 25, 2011	May 6, 2011
20	May 2, 2011	May 13, 2011
21	May 9, 2011	May 20, 2011
22	May 16, 2011	May 27, 2011
23	May 23, 2011	June 3, 2011

24	May 31, 2011	June 10, 2011
25	June 6, 2011	June 17, 2011
26	June 13, 2011	June 24, 2011
27	June 20, 2011	July 1, 2011
28	June 27, 2011	July 8, 2011
29	July 5, 2011	July 15, 2011
30	July 11, 2011	July 22, 2011
31	July 18, 2011	July 29, 2011
32	July 25, 2011	August 5, 2011
33	August 1, 2011	August 12, 2011
34	August 8, 2011	August 19, 2011
35	August 15, 2011	August 26, 2011
36	August 22, 2011	September 2, 2011
37	August 29, 2011	September 9, 2011
38	September 6, 2011	September 16, 2011
39	September 12, 2011	September 23, 2011
40	September 19, 2011	September 30, 2011
41	September 26, 2011	October 7, 2011
42	October 3, 2011	October 14, 2011
43	October 11, 2011	October 21, 2011
44	October 17, 2011	October 28, 2011
45	October 24, 2011	November 4, 2011
46	October 31, 2011	November 14, 2011
47	November 7, 2011	November 18, 2011
48	November 14, 2011	November 28, 2011
49	November 21, 2011	December 2, 2011
50	November 28, 2011	December 9, 2011
51	December 5, 2011	December 16, 2011
52	December 12, 2011	December 27, 2011
53	December 19, 2011	December 30, 2011

**Editor's Note:** The Secretary of State Index Department is providing this opportunity to remind you that the next filing period for your Regulatory Agenda will occur from May 2, to July 1, 2011.

## DEPARTMENT OF AGRICULTURE

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Insect Pest and Plant Disease Act
- 2) Code Citation: 8 Ill. Adm. Code 240
- 3) Section Number: 240.140                      Proposed Action:  
Amendment
- 4) Statutory Authority: The Insect Pest and Plant Disease Act [505 ILCS 90]
- 5) A Complete Description of the Subjects and Issues Involved: The Department is amending the fee for an original certificate from the current rate of \$75 per certificate to \$100 per certificate to more closely mirror the recent change to the fee associated with federal issuance of those certificates. Beginning October 1, 2010, the fee for a federally-issued phytosanitary certificate became \$104 per certificate and on October 1, 2011, the rate is scheduled to increase to \$106 per certificate.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: A 45-day written comment period will begin on the day the Notice of Proposed Amendment appears in the *Illinois Register*. Please mail written comments on the proposed rulemaking to the attention of:

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

## DEPARTMENT OF AGRICULTURE

## NOTICE OF PROPOSED AMENDMENT

217/785-5713

217/785-4505 (fax)

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking will impact small businesses that export agricultural products to foreign countries.
  - B) Reporting, bookkeeping or other procedures required for compliance: None beyond the current requirements.
  - C) Types of professional skills necessary for compliance: None beyond the current requirements
- 14) Regulatory agenda on which this rulemaking was summarized: This rule was not included in either of the two most recent agendas because: the Department was not certain that the federal government would increase their certificate fees.

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

## DEPARTMENT OF AGRICULTURE

## NOTICE OF PROPOSED AMENDMENT

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

PART 240  
 INSECT PEST AND PLANT DISEASE ACT

SUBPART A: NURSERY AND NURSERY STOCK;  
 INSPECTION; CERTIFICATES

Section	
240.10	Storage and Display of Nursery Stock
240.20	Inspection of Shipments of Nursery Stock in Transit
240.30	Infested or Infected Shipments of Nursery Stock; Disposal or Treatment
240.40	Listing of Other States' Certified Nurseries
240.50	Revocation of Certificates
240.60	Special Certification: Sales, Trades, and Auctions by Garden Clubs and Social Organizations
240.70	Special Certification: Plants and Nursery Stock Shipped by Individual Residents
240.80	Inspection of Private Premises, Public Grounds and Forest Preserves
240.90	Inspection of Native Trees for Resale
240.100	Refusal to Inspect Nursery
240.110	Sale of Nursery Stock Which is Infected Prohibited
240.120	Nursery Certificates Withheld or Qualified Certificates Issued
240.125	Firewood Importer Certificates
240.130	Inspection of Shipments for Foreign Countries
240.140	Fee Schedule
240.150	Use of the Department of Agriculture for Advertising (Repealed)
240.160	Administrative Rules (Formal Administrative Hearings; Contested Cases; Petitions; Administrative Procedures)

## SUBPART B: QUARANTINE

Section	
240.250	Scope
240.260	Definitions
240.270	Restrictions and Regulated Articles
240.280	Movement of Regulated Articles
240.290	Issuance and Cancellation of Permits, Certificates of Inspection or Compliance

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT

Agreements

- 240.300 Attachment of Certificates, Permits or Agreements
- 240.310 Inspection and Disposal of Regulated Articles
- 240.320 Duration of Quarantine

AUTHORITY: Implementing and authorized by The Insect Pest and Plant Disease Act [505 ILCS 90].

SOURCE: Rules and Regulations Relating to the Insect Pest and Plant Disease Act, filed October 25, 1974, effective November 2, 1974; codified at 5 Ill. Reg. 10523; amended at 6 Ill. Reg. 3041, effective March 5, 1982; amended at 7 Ill. Reg. 1764, effective January 28, 1983; amended at 12 Ill. Reg. 8299, effective May 2, 1988; amended at 26 Ill. Reg. 14661, effective September 23, 2002; amended at 30 Ill. Reg. 133, effective January 1, 2006; amended at 33 Ill. Reg. 203, effective January 1, 2009; amended at 34 Ill. Reg. 3743, effective March 15, 2010; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

SUBPART A: NURSERY AND NURSERY STOCK; INSPECTION; CERTIFICATES

**Section 240.140 Fee Schedule**

The Department shall charge and collect fees for inspection and issuance of certificates according to the following schedule:

- a) Nursery Inspection  
Nursery inspection fees shall be as follows:
 

1 acre or less	\$25.00
over 1 acre but less than or equal to 5 acres	\$30.00
over 5 acres but less than or equal to 10 acres	\$40.00
over 10 acres but less than or equal to 50 acres	\$50.00
over 50 acres but less than or equal to 100 acres	\$75.00
over 100 acres but less than or equal to 250 acres	\$150.00
over 250 acres but less than or equal to 500 acres	\$180.00
over 500 acres (per acre)	\$0.50
  
- b) Greenhouse Inspection  
Greenhouses that request inspection shall be charged the special inspection and certificate fees in subsection (d).

## DEPARTMENT OF AGRICULTURE

## NOTICE OF PROPOSED AMENDMENT

- c) Nursery Dealer Certificates
- 1) Effective January 1, 2003 through December 31, 2005, the rate for a nursery dealer certificate shall be \$25.
  - 2) Effective January 1, 2006, the rate for a nursery dealer certificate shall be \$50.
- d) Special (Requested) Inspections  
Effective January 1, 2003, the inspection rate charged for special inspections shall be \$25 per hour and the rate charged for individual certificates for special inspections shall be \$25 per certificate.
- e) Original certificates are required to accompany nursery stock and/or plants and plant products for shipment or sale verifying they are free of insect pests and plant diseases.
- 1) Effective January 1, 2003 through December 31, 2005, the rate for original certificates shall be \$25 each.
  - 2) Effective January 1, 2006 through June 30, 2010, the rate for original certificates shall be \$50 each.
  - 3) Effective July 1, 2010 [through December 31, 2011](#), the rate for original certificates shall be \$75 each.
  - 4) [Effective January 1, 2012, the rate for original certificates shall be \\$100 each.](#)
- f) Firewood Importer Certificates  
Effective January 1, 2009, the rate for a firewood importer certificate shall be \$25.

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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities
- 2) Code Citation: 89 Ill. Adm. Code 147
- 3) Section Number: 147.150                      Proposed Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and PA 96-1530
- 5) Complete Description of the Subjects and Issues Involved: The proposed amendment implements Public Act 96-1530, providing \$222.5 million in additional funds for Minimum Data Set (MDS) reimbursement for nursing facilities.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

217/782-123

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
  - A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid certified nursing facilities
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on Which this Rulemaking Was Summarized: January 2010

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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER d: MEDICAL PROGRAMS

## PART 147

## REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

## Section

147.5	Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System
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
147.150	Minimum Data Set (MDS) Based Reimbursement System
147.175	Minimum Data Set (MDS) Integrity
147.200	Minimum Data Set (MDS) On-Site Review Documentation
147.205	Reimbursement for Ventilator Dependent Residents
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 Specialized Services for Individuals with Developmental Disabilities in Nursing

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

## Facilities

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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)

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

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17 Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended at 32 Ill. Reg. 8614, effective May 29, 2008; amended at 33 Ill. Reg. 9337, effective July 1, 2009; emergency amendment at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; emergency amendment modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 14, 2010; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 147.150 Minimum Data Set (MDS) Based Reimbursement System**

- a) Public Act 94-0964 requires the Department to implement, effective January 1, 2007, a payment methodology for the nursing component of the rate paid to nursing facilities. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, reimbursement for the nursing 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) Except as referenced in subsection (c)(1)(E)(iv) of this Section, the nursing component of the rate shall be calculated and 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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.

- c) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.
- 1) Variable Time Reimbursement.  
Variable nursing time is that time necessary to meet the major service needs of residents that 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 147. Table A). Reimbursement is developed by multiplying the time for each service by the wages 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. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:
- A) The mean wages for the applicable staff levels (RNs, LPNs, certified nursing assistants (CNAs), activity staff, social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.
- B) Fringe benefits will be the average percentage of benefits to actual salaries of all nursing facilities based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the mean wage.
- C) 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) Special minimum wage factor. The process used in subsection

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

(c)(1)(A) of this Section to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.

- E) Beginning January 1, 2007, facilities shall be paid a rate based upon the sum of the following:
- i) the facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006 funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology and the weighted mean rate in effect on December 31, 2006.
  - ii) the facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569(a)(1), multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). The exceptional care reimbursement per diem effective January 1, 2007 computed in 89 Ill. Adm. Code 140.569 shall be included in the nursing component of the June 30, 2006 rate unless the total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive for the rate period zero percent of the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569.
  - iii) Until October 1, 2009, for facilities in which the number of ventilator care residents in any quarter has increased over the number used to compute the exceptional care per diem

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

as specified in 89 Ill. Adm. Code 140.569(a)(1), the rate computed in subsections (c)(1)(E)(i) and (c)(1)(E)(ii) shall add the sum of total variable time reimbursement for the ventilator care add-on, vacation time, the average facility special patient need factors, and supply, consultant, and Director of Nursing factors for each resident receiving ventilator care in excess of the number used to compute the exceptional care per diem as specified in 89 Ill. Adm. Code 140.569(a)(1) divided by the total number of residents used to compute the MDS portion of the paid rate for that quarter. The resulting ventilator add-on shall be multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). This addition to the rate shall apply for each quarter regardless of the facility's eligibility for use of that quarter's MDS rate for computation of the paid facility rate as defined in subsection (b) of this Section.

iv) The calculations referenced in subsections (c)(1)(E)(i) and (ii) of this Section shall only change annually.

F) The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007 is \$60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008 is \$50 million. The annual amount of new funds for MDS reimbursement methodology beginning January 1, 2009 is \$84 million. Subject to approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the annual amount of new funds for MDS reimbursement methodology, beginning May 1, 2011, is \$222.5 million.

- 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 of variable time by 5%.
- 3) Special Supplies, Consultants and the Director of Nursing.  
Reimbursement will be made 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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 and programs salaries.
  - 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.
  - C) These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).
- d) **Determination of Facility Rates.**  
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)(1) of this Section), adding the amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section), and supplies, consultants, and the Director of Nursing (see subsection (c)(3) of this Section). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.
- 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 December 31, 2006, 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:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 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) January 1, 2007.
- 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.

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

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- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.125                      Proposed Action:  
Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and PA 96-1530
- 5) Complete Description of the Subjects and Issues Involved: This rulemaking implements provisions of Public Act 96-1530, and provides that effective May 1, 2011, Medicaid certified Institution for Mental Diseases (IMDs) will have the nursing component of their rate fully funded using the MDS methodology, and will also receive an increase to their socio-development component rate. The socio-development component rate increase will be equal to two-thirds of the difference between the highest nursing rate among the Medicaid certified IMD facilities and the individual IMD's nursing rate. This rate change is subject to approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.  
  
In addition, effective May 1, 2011, facilities that are federally defined as IMDs, and determined to be Subpart T facilities, will receive an increase to their socio-development component rate of \$.50 per day, per resident.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

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

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

217/782-1233

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid-certified Institutions for Mental Disease (IMDs)
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: January 2011

The text of the Proposed Amendment is the next page.

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## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## 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
153.126	Long Term Care Facility Medicaid Per Diem Adjustments
153.150	Quality Assurance Review (Repealed)

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

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 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. 18880, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 10218,

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effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15584, effective November 24, 2004; emergency amendment at 29 Ill. Reg. 1026, effective January 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 4740, effective March 18, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 6979, effective May 1, 2005; amended at 29 Ill. Reg. 12452, effective August 1, 2005; emergency amendment at 30 Ill. Reg. 616, effective January 1, 2006, for a maximum of 150 days; emergency amendment modified pursuant to the Joint Committee on Administrative Rules Objection at 30 Ill. Reg. 7817, effective April 7, 2006, for the remainder of the maximum 150 days; amended at 30 Ill. Reg. 10417, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11853, effective July 1, 2006, for a maximum of 150 days; emergency expired November 27, 2006; amended at 30 Ill. Reg. 14315, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 18779, effective November 28, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 6954, effective April 26, 2007; emergency amendment at 32 Ill. Reg. 535, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 4105, effective March 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 7761, effective May 5, 2008; amended at 32 Ill. Reg. 9972, effective June 27, 2008; amended at 33 Ill. Reg. 9347, effective July 1, 2009; emergency amendment at 34 Ill. Reg. 17462, effective November 1, 2010, for a maximum of 150 days; amended at 35 Ill. Reg. 6171, effective March 28, 2011; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 153.125 Long Term Care Facility Rate Adjustments**

- a) 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 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;

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- 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 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 facility's status changes so as to be exempt from assessment to pay real estate taxes.
  - 3) 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.
  - 4) 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

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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.
- 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.
- n) Notwithstanding the provisions set forth in Section 153.100, pending the approvals described in this subsection (n), nursing facility (SNF/ICF) rates

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effective July 1, 2004 shall be 3.0 percent greater than the rates in effect on June 30, 2004. The increase is contingent on approval of both the payment methodologies required under Article 5A-12 of the Public Aid Code [305 ILCS 5/5A-12] and the waiver granted under 42 CFR 433.68.

- o) Notwithstanding the provisions set forth in Section 153.100, the "Original Building Base Cost" for nursing facilities (SNF/ICF) which have been rented continuously from an unrelated party since prior to January 1, 1978, effective on July 1, 2004, shall be added to the capital rate calculation using the most recent cost reports on file with the Department no later than June 30, 2004. The "Original Building Base Cost" as defined in 89 Ill. Adm. Code 140.570 shall be calculated from the original lease information that is presently on file with the Department. This original lease information will be used to capitalize the oldest available lease payment from the unrelated party lease that has been in effect since prior to January 1, 1978, and continued to be in effect on December 31, 1999. Before the lease payment is capitalized, a 15 percent portion will be removed from the oldest available lease payment for movable equipment costs. After the lease payment is capitalized, a portion of the capitalized amount will be removed for land cost. The land cost portion is 4.88 percent. The remaining amount will be the facility's building cost. The construction/acquisition year for the building will be the date the pre-1978 lease began. The allowable cost of subsequent improvements to the building will be included in the original building base cost. The original building base cost will not change due to sales or leases of the facility after January 1, 1978.
- p) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on January 1, 2005 will be 3.0 percent more than the rates in effect on December 31, 2004.
- q) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates shall be increased by the difference between a facility's per diem property, liability and malpractice insurance costs as reported in the cost report that was filed with the Department and used to establish rates effective July 1, 2001, and those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations.
- r) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on January 1, 2006 for intermediate care facilities for persons with developmental

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disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 3 percent.

- s) Notwithstanding the provisions set forth in Section 153.100, developmental training 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), effective on January 1, 2006 shall be increased by 3 percent.
- t) Notwithstanding the provisions set forth in Section 153.100, for facilities that are federally defined as Institutions for Mental Disease (see Section 145.30), a socio-development component rate equal to 6.6% of the nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. This rate shall become a part of the facility's nursing component of the Medicaid rate. While this rate may be adjusted by the Department, the rate shall not be reduced.
- u) Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on January 1, 2008 shall be computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.
  - 1) Support rates taking effect on January 1, 2008 shall be adjusted based on audits of cost report data in accordance with 89 Ill. Adm. Code 140.582(b) and 140.590. The audited cost report data will be used to retroactively update the resulting support rate effective January 1, 2008, after the 45-day appeal period from Section 140.582(b) has passed.
  - 2) 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 this subsection (u) 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.
- v) Notwithstanding the provisions set forth in Section 153.100, pursuant to Public Act 95-0744, for services beginning August 1, 2008, the socio-development component for facilities that are federally defined as Institutions for Mental

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Disease (see 89 Ill. Adm. Code 145.30) shall equal 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53.

- w) Notwithstanding the provisions set forth in Section 153.100, pursuant to Public Act 95-0744, for services beginning January 1, 2009, the support component for skilled and intermediate care facilities that was effective on January 1, 2008, computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006, shall be increased to the amount that would have been derived using standard Department of Healthcare and Family Services methods, procedures and inflators described in Sections 140.533, 140.551, 140.553 and 140.561.
- x) Notwithstanding the provisions set forth in Section 153.100, effective November 1, 2010, the program and support components of the per diem rate for ICF/MR qualifying under 89 Ill. Adm. Code 144.102 shall be adjusted in accordance with that Section.
- y) Notwithstanding the provisions set forth in Section 153.100, pursuant to Public Act 96-1530, for services beginning May 1, 2011, the socio-development component for facilities that are federally defined as Institutions for Mental Disease (IMD) (see 89 Ill. Adm. Code 145.30) and that are Medicaid certified will have the nursing component of their rate fully funded using the MDS methodology and will also receive an increase to their socio-development component rate. The socio-development component rate increase will be equal to two-thirds of the difference between the highest nursing rate among the Medicaid certified IMD facilities and the individual IMD's nursing rate. This rate change is subject to approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.
- z) Notwithstanding the provisions set forth in Section 153.100, effective for services beginning May 1, 2011, facilities that are federally defined as Institutions for Mental Disease (see 89 Ill. Adm. Code 145.30) and determined to be Subpart T facilities (see 89 Ill. Adm. Code 145.10) will receive an increase to their socio-development component rate of \$.50 per day, per resident.

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

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Narrative and Planning Policies
- 2) Code Citation: 77 Ill. Adm. Code 1100
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1100.660	Repeal
1100.670	Repeal
- 4) Statutory Authority: Illinois Health Facilities Planning Act [20 ILCS 3960]
- 5) A Complete Description of the Subjects and Issues Involved: The Health Facilities Planning Act [20 ILCS 3960/12] mandates the establishment of a separate set of rules and guidelines pertaining to long-term care (LTC). The proposed rules will establish 77 Ill. Adm. Code 1125, consolidating the definitions; planning policies; review criteria; and standards for General Long-Term Care, as well as Specialized Long-Term Care.  
  
Existing long-term care rules currently housed in 77 Ill. Adm. Codes 1100 and 1110 will be relocated to the new 77 Ill. Adm. Code 1125 and simultaneously repealed from 1100 and 1110.
- 6) Published studies or reports, and sources of underlying data used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate as defined in Section 3(b) of the State mandates Act [30 ILCS 805/3(b)].
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Public Hearing  
to be conducted on

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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Wednesday, May 18, 2011  
10:00 a.m. – 2:00 p.m.  
Oak Forest City Council Chambers  
15440 S. Central Avenue  
Oak Forest, Illinois

Interested persons may present their comments concerning this rulemaking within 45 days after the publication of this issue of the Illinois Register to:

Claire Burman  
Coordinator, Rules Development  
Illinois Health Facilities and Services Review Board  
122 S. Michigan Avenue, 7th Floor  
Chicago, Illinois 60603

312/814-4825  
e-mail: [Claire.Burman@illinois.gov](mailto:Claire.Burman@illinois.gov)

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Long-term care facilities
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent Regulatory Agendas because: the need for the rulemaking was not apparent when the Regulatory Agenda was prepared.

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

HEALTH FACILITIES AND SERVICES REVIEW BOARD

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH

CHAPTER II: HEALTH FACILITIES AND SERVICES REVIEW BOARD

SUBCHAPTER a: ILLINOIS HEALTH CARE FACILITIES PLAN

PART 1100

NARRATIVE AND PLANNING POLICIES

SUBPART A: GENERAL NARRATIVE

Section

1100.10	Introduction
1100.20	Authority
1100.30	Purpose
1100.40	Health Maintenance Organizations (Repealed)
1100.50	Subchapter Organization
1100.60	Mandatory Reporting of Data
1100.70	Data Appendices
1100.75	Annual Bed Report
1100.80	Institutional Master Plan Hospitals (Repealed)
1100.90	Public Hearings

SUBPART B: DEFINITIONS

Section

1100.210	Introduction
1100.220	Definitions

SUBPART C: PLANNING POLICIES

Section

1100.310	Need Assessment
1100.320	Staffing
1100.330	Professional Education
1100.340	Public Testimony
1100.350	Multi-Institutional Systems
1100.360	Modern Facilities
1100.370	Occupancy/Utilization Standards
1100.380	Systems Planning
1100.390	Quality

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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1100.400	Location
1100.410	Needed Facilities
1100.420	Discontinuation
1100.430	Coordination with Other State Agencies
1100.440	Requirements for Authorized Hospital Beds

## SUBPART D: NEED ASSESSMENT

## Section

1100.510	Introduction, Formula Components, Planning Area Development Policies, and Normal Travel Time Determinations
1100.520	Medical-Surgical/Pediatric Categories of Service
1100.530	Obstetric Care Category of Service
1100.540	Intensive Care Category of Service
1100.550	Comprehensive Physical Rehabilitation Category of Service
1100.560	Acute Mental Illness Treatment Category of Service
1100.570	Substance Abuse/Addiction Treatment Category of Service (Repealed)
1100.580	Neonatal Intensive Care Category of Service
1100.590	Burn Treatment Category of Service (Repealed)
1100.600	Therapeutic Radiology Equipment (Repealed)
1100.610	Open Heart Surgery Category of Service
1100.620	Cardiac Catheterization Services
1100.630	In-Center Hemodialysis Category of Service
1100.640	Non-Hospital Based Ambulatory Surgery
1100.650	Computer Systems (Repealed)
1100.660	General Long-Term Nursing Care Category of Service ( <a href="#">Repealed</a> )
1100.661	General Long-Term Care-Sheltered Care Category of Service (Repealed)
1100.670	Specialized Long-Term Care Categories of Service ( <a href="#">Repealed</a> )
1100.680	Intraoperative Magnetic Resonance Imaging Category of Service (Repealed)
1100.690	High Linear Energy Transfer (L.E.T.) (Repealed)
1100.700	Positron Emission Tomographic Scanning (P.E.T.) (Repealed)
1100.710	Extracorporeal Shock Wave Lithotripsy (Repealed)
1100.720	Selected Organ Transplantation
1100.730	Kidney Transplantation
1100.740	Subacute Care Hospital Model
1100.750	Postsurgical Recovery Care Center Alternative Health Care Model
1100.760	Children's Respite Care Center Alternative Health Care Model
1100.770	Community-Based Residential Rehabilitation Center Alternative Health Care Model

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1100.800 Freestanding Emergency Center Medical Services Category of Service  
1100.810 Long-Term Acute Care Hospital Category of Service

1100.APPENDIX A Applicable Codes and Standards Utilized in 77 Ill. Adm. Code: Chapter II, Subchapter a (Repealed)

AUTHORITY: Authorized by Section 12 of and implementing the Illinois Health Facilities Planning Act [20 ILCS 3960/12].

SOURCE: Fourth Edition adopted at 3 Ill. Reg. 30, p. 194, effective July 28, 1979; amended at 4 Ill. Reg. 4, p. 129, effective January 11, 1980; amended at 5 Ill. Reg. 4895, effective April 22, 1981; amended at 5 Ill. Reg. 10297, effective September 30, 1981; amended at 6 Ill. Reg. 3079, effective March 8, 1982; emergency amendments at 6 Ill. Reg. 6895, effective May 20, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 11574, effective September 9, 1982; Fifth Edition adopted at 7 Ill. Reg. 5441, effective April 15, 1983; amended at 8 Ill. Reg. 1633, effective January 31, 1984; codified at 8 Ill. Reg. 15476; amended at 9 Ill. Reg. 3344, effective March 6, 1985; amended at 11 Ill. Reg. 7311, effective April 1, 1987; amended at 12 Ill. Reg. 16079, effective September 21, 1988; amended at 13 Ill. Reg. 16055, effective September 29, 1989; amended at 16 Ill. Reg. 16074, effective October 2, 1992; amended at 18 Ill. Reg. 2986, effective February 10, 1994; amended at 18 Ill. Reg. 8448, effective July 1, 1994; emergency amendment at 19 Ill. Reg. 1941, effective January 31, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 2985, effective March 1, 1995; amended at 19 Ill. Reg. 10143, effective June 30, 1995; recodified from the Department of Public Health to the Health Facilities Planning Board at 20 Ill. Reg. 2594; amended at 20 Ill. Reg. 14778, effective November 15, 1996; amended at 21 Ill. Reg. 6220, effective May 30, 1997; expedited correction at 21 Ill. Reg. 17201, effective May 30, 1997; amended at 23 Ill. Reg. 2960, effective March 15, 1999; amended at 24 Ill. Reg. 6070, effective April 7, 2000; amended at 25 Ill. Reg. 10796, effective August 24, 2001; amended at 27 Ill. Reg. 2904, effective February 21, 2003; amended at 31 Ill. Reg. 15255, effective November 1, 2007; amended at 32 Ill. Reg. 4743, effective March 18, 2008; amended at 32 Ill. Reg. 12321, effective July 18, 2008; expedited correction at 33 Ill. Reg. 4040, effective July 18, 2008; amended at 34 Ill. Reg. 6067, effective April 13, 2010; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART D: NEED ASSESSMENT

| **Section 1100.660 General Long-Term Nursing Care Category of Service [\(Repealed\)](#)**

| a) [Planning Areas](#)

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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~~The 95 general long term nursing care planning areas are located within the 11 HSAs.~~

- ~~1) HSA 1: Planning areas are Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago Counties.~~
- ~~2) HSA 2: Planning areas are Bureau/Putnam Counties (combined), Henderson/Warren Counties (combined), Marshall/Stark Counties (combined), Fulton, Knox, LaSalle, McDonough, Peoria, Tazewell and Woodford Counties.~~
- ~~3) HSA 3: Planning areas are Brown/Schuyler Counties (combined), Calhoun/Pike Counties (combined), Morgan/Scott Counties (combined), Adams, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery and Sangamon Counties.~~
- ~~4) HSA 4: Planning areas are Coles/Cumberland Counties (combined), Champaign, Clark, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, McLean, Macon, Moultrie, Piatt, Shelby and Vermilion Counties.~~
- ~~5) HSA 5: Planning areas are Alexander/Pulaski Counties (combined), Edwards/Wabash Counties (combined), Gallatin/Hamilton/Saline Counties (combined), Johnson/Massac Counties (combined), Hardin/Pope Counties (combined), Bond, Clay, Crawford, Effingham, Fayette, Franklin, Jackson, Jasper, Jefferson, Lawrence, Marion, Perry, Randolph, Richland, Union, Washington, Wayne, White and Williamson Counties.~~
- ~~6) HSA 6: Planning Areas~~
  - ~~A) 6A: City of Chicago Community Areas Rogers Park, West Ridge, Uptown, Lincoln Squire, Edgewater, Edison Park, Norwood Park, Jefferson Park, Forest Glen, North Park, Albany Park, Portage Park, Irving Park and Avondale.~~
  - ~~B) 6B: City of Chicago Community Areas North Center, Lakeview, Lincoln Park, Near North Side, Loop, Logan Square, West Town, Near West Side, Lower West Side, West Garfield Park, East Garfield Park, North Lawndale, South Lawndale, O'Hare, Dunning, Montclare, Belmont Cragin, Hermosa, Humboldt Park~~

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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~~and Austin.~~

- C) ~~6C: City of Chicago Community Areas Near North Side, Armour Square, Douglas, Oakland, Fuller Park, Grand Boulevard, Kenwood, Washington Park, Hyde Park, Woodlawn, South Shore, Chatham, Avalon Park, South Chicago, Burnside, Calumet Heights, Roseland, Pullman, South Deering, East Side, West Pullman, Riverdale, Hegewisch, Garfield Ridge, Archer Heights, Brighton Park, McKinley Park, Bridgeport, New City, West Elson, Gage Park, Clearing, West Lawn, Chicago Lawn, West Englewood, Englewood, Greater Grand Crossing, Ashburn, Auburn Gresham, Beverly, Washington Heights, Mount Greenwood and Morgan Park.~~
- 7) ~~HSA 7: Planning Areas~~
- A) ~~7A: Cook County Townships of Barrington, Palatine, Wheeling, Hanover, Schaumburg and Elk Grove.~~
- B) ~~7B: Cook County Townships of Northfield, New Trier, Evanston, Niles and Maine.~~
- C) ~~7C: DuPage County.~~
- D) ~~7D: Cook County Townships of Norwood Park, Leyden, Proviso, River Forest, Oak Park, Riverside, Berwyn and Cicero.~~
- E) ~~7E: Cook County Townships of Lyons, Lemont, Palos, Orland, Stickney, Worth, Calumet, Bremen, Thornton, Rich and Bloom.~~
- 8) ~~HSA 8: Planning areas are Kane, Lake and McHenry Counties.~~
- 9) ~~HSA 9: Planning areas are Grundy, Kankakee, Kendall and Will Counties.~~
- 10) ~~HSA 10: Planning areas are Henry, Mercer and Rock Island Counties.~~
- 11) ~~HSA 11: Planning areas are Clinton, Madison, Monroe and St. Clair Counties.~~

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- b) ~~Age Groups~~  
~~For general long-term nursing care, age groups of 0-64, 65-74, and 75 and over.~~
- e) ~~Utilization Target~~  
~~Facilities providing a general long-term nursing care service should operate those beds at a minimum annual average occupancy of 90% or higher.~~
- d) ~~Bed Capacity~~  
~~General long-term nursing care bed capacity is the licensed capacity for facilities subject to the Nursing Home Care Act and the total number of LTC beds for a facility as determined by HFPB pursuant to this Part for facilities not subject to the Nursing Home Care Act.~~
- e) ~~Need Determination~~  
~~The following methodology is utilized to determine the projected number of nursing care beds needed in a planning area:~~
  - 1) ~~Establish minimum and maximum planning area use rates for the 0-64, the 65-74, and the 75 and over age groups as follows:~~
    - A) ~~Divide the HSA's base year experienced nursing care patient days for each age group by the base year population estimate for each age group to determine the HSA experienced use rate for each age group;~~
    - B) ~~the minimum planning area use rate for each age group is 60% of the HSA experienced use rate for each age group, and the maximum planning area use rate for each age group is 160% of the HSA experienced use rate for each age group;~~
  - 2) ~~Divide the planning area's base year experienced nursing care patient days for each age group by the base year population estimate for each group to determine the planning area experienced use rate for each age group;~~
  - 3) ~~Determine the planning area's population projection, which is 10 years from the base year; the use rate for each age group is as follows:~~

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- A) ~~If the experienced use rate for an age group is below the minimum use rate, the minimum use rate is the projected use rate for that age group;~~
- B) ~~If the experienced use rate for an age group is above the maximum use rate, the maximum use rate is the projected use rate for that age group;~~
- C) ~~If the experienced use rate for an age group is above the minimum use rate and below the maximum use rate, the experienced use rate for the age group is the projected use rate for that age group;~~
- 4) ~~Multiply each age group's projected use rate times the projected population for the age group to determine the projected patient days for each age group;~~
- 5) ~~Total the projected patient days for the age groups to determine the planning area's total projected patient days;~~
- 6) ~~Divide the planning area's total projected patient days by the number of days in the projected year to obtain the projected average daily census;~~
- 7) ~~Divide the projected average daily census by .90 (90% occupancy factor) to obtain the projected planning area bed need;~~
- 8) ~~Subtract the number of existing beds in the planning area from the projected planning area bed need to determine the projected number of excess (surplus) beds or the projected need for additional (deficit) beds in an area.~~

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

**Section 1100.670 Specialized Long-Term Care Categories of Service (Repealed)**

- a) ~~Categories of Service:~~
  - 1) ~~Chronic Mental Illness (MI);~~
  - 2) ~~Long Term Care for the Developmentally Disabled (Adult) (DD-Adult);~~

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and

- 3) ~~Long-Term Care for the Developmentally Disabled (Children) (DD-Children).~~
- b) ~~Planning Areas:~~
- 1) ~~The State of Illinois is utilized for the MI category of service.~~
  - 2) ~~Health Service Areas are utilized for the DD-Children category of service.~~
  - 3) ~~For DD-Adult category of service:~~  
  
~~HSA I, HSA II, HSA III, HSA IV, HSA V, HSA X, HSA XI, and the combined HSAs VI, VII, VIII and IX.~~
- e) ~~Occupancy Targets:~~
- 1) ~~Modernization 80%; Additional Beds 90% for the MI category of service; and~~
  - 2) ~~Modernization 80%; Additional Beds 93% for the DD-Adult and DD-Children categories of service.~~
- d) ~~Bed Capacity: For facilities licensed pursuant to the Nursing Home Care Act [210 ILCS 45], the bed capacity is the licensed bed capacity for the service.~~
- e) ~~Bed Need Determination for the Specialized Categories of Service:~~
- 1) ~~No formula bed need for the MI and DD-Children categories of service has been developed. It is the responsibility of the applicant to document the need for the service by complying with all applicable review criteria contained in 77 Ill. Adm. Code 1110, Subpart S.~~
  - 2) ~~Bed need for the DD-Adult category of service is calculated in two parts:~~
    - A) ~~For facilities licensed as ICF/DD 16-bed or fewer, total bed need and the number of additional beds needed are determined by dividing the planning area's projected adult developmentally~~

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~~disabled population by 21.4 to determine the total number of beds needed for developmentally disabled adult residents in the planning area. The number of additional beds needed or excess beds is determined by subtracting the number of existing beds in ICF/DD 16 bed or fewer facilities from the total number of beds needed for developmentally disabled adult residents in the planning area.~~

- B) ~~For facilities with more than 16 beds, no bed need formula has been established.~~

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

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- 1) Heading of the Part: Processing, Classification Policies and Review Criteria
- 2) Code Citation: 77 Ill. Adm. Code 1110
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1110.1730	Repeal
1110.1810	Repeal
1110.1820	Repeal
1110.1830	Repeal
- 4) Statutory Authority: Illinois Health Facilities Planning Act [20 ILCS 3960]
- 5) A Complete Description of the Subjects and Issues Involved The Health Facilities Planning Act [20 ILCS 3960/12] mandates the establishment of a separate set of rules and guidelines pertaining to long-term care (LTC). The proposed rules will establish 77 Ill. Adm. Code 1125, consolidating the definitions; planning policies; review criteria; and standards for General Long-Term Care, as well as Specialized Long-Term Care.  
  
Existing long-term care rules currently housed in 77 Ill. Adm. Codes 1100 and 1110 will be relocated to the new 77 Ill. Adm. Code 1125 and simultaneously repealed from 1100 and 1110.
- 6) Published studies or reports, and sources of underlying data used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemakings does not create or expand a State mandate as defined in Section 3(b) of the State mandates Act [30 ILCS 805/3(b)].
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

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Public Hearing  
to be conducted on  
Wednesday, May 18, 2011  
10:00 a.m. – 2:00 p.m.  
Oak Forest City Council Chambers  
15440 S. Central Avenue  
Oak Forest, Illinois

Interested persons may present their comments concerning this rulemaking within 45 days after the publication of this issue of the *Illinois Register* to:

Claire Burman  
Coordinator, Rules Development  
Illinois Health Facilities and Services Review Board  
122 S. Michigan Avenue, 7th Floor  
Chicago, Illinois 60603

312/814-4825  
e-mail: [Claire.Burman@illinois.gov](mailto:Claire.Burman@illinois.gov)

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Long-term care facilities
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: the need for the rulemaking was not apparent when the Regulatory Agenda was prepared.

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

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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## TITLE 77: PUBLIC HEALTH

## CHAPTER II: HEALTH FACILITIES AND SERVICES REVIEW BOARD

## SUBCHAPTER a: ILLINOIS HEALTH CARE FACILITIES PLAN

## PART 1110

## PROCESSING, CLASSIFICATION POLICIES AND REVIEW CRITERIA

## SUBPART A: GENERAL APPLICABILITY AND PROJECT CLASSIFICATION

## Section

- 1110.10 Introduction and Applicability
- 1110.20 Projects Required to Obtain a Permit (Repealed)
- 1110.30 Processing and Reviewing Applications (Repealed)
- 1110.40 Classification of Projects and Applicable Review Criteria
- 1110.50 Recognition of Services which Existed Prior to Permit Requirements (Repealed)
- 1110.55 Recognition of Non-hospital Based Ambulatory Surgery Category of Service (Repealed)
- 1110.60 Master Design Projects (Repealed)
- 1110.65 Master Plan or Capital Budget Projects (Repealed)

## SUBPART B: REVIEW CRITERIA – DISCONTINUATION

## Section

- 1110.110 Introduction (Repealed)
- 1110.120 Discontinuation – Definition (Repealed)
- 1110.130 Discontinuation – Review Criteria

## SUBPART C: GENERAL PURPOSE, MASTER DESIGN, AND FACILITY CONVERSION – INFORMATION REQUIREMENTS AND REVIEW CRITERIA

## Section

- 1110.210 Introduction
- 1110.220 Definitions – General Review Criteria (Repealed)
- 1110.230 Project Purpose, Background and Alternatives – Information Requirements
- 1110.234 Project Scope and Size, Utilization and Unfinished/Shell Space – Review Criteria
- 1110.235 Additional General Review Criteria for Master Design and Related Projects Only
- 1110.240 Changes of Ownership, Mergers and Consolidations

## SUBPART D: REVIEW CRITERIA RELATING TO ALL PROJECTS

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INVOLVING ESTABLISHMENT OF ADDITIONAL BEDS  
OR SUBSTANTIAL CHANGE IN BED CAPACITY

Section

- 1110.310 Introduction (Repealed)
- 1110.320 Bed Related Review Criteria (Repealed)

SUBPART E: MODERNIZATION REVIEW CRITERIA

Section

- 1110.410 Introduction (Repealed)
- 1110.420 Modernization Review Criteria (Repealed)

SUBPART F: CATEGORY OF SERVICE REVIEW CRITERIA –  
MEDICAL/SURGICAL, OBSTETRIC, PEDIATRIC AND INTENSIVE CARE

Section

- 1110.510 Introduction (Repealed)
- 1110.520 Medical/Surgical, Obstetric, Pediatric and Intensive Care – Definitions (Repealed)
- 1110.530 Medical/Surgical, Obstetric, Pediatric and Intensive Care – Review Criteria

SUBPART G: CATEGORY OF SERVICE REVIEW CRITERIA –  
COMPREHENSIVE PHYSICAL REHABILITATION

Section

- 1110.610 Introduction (Repealed)
- 1110.620 Comprehensive Physical Rehabilitation – Definitions (Repealed)
- 1110.630 Comprehensive Physical Rehabilitation – Review Criteria

SUBPART H: CATEGORY OF SERVICE REVIEW CRITERIA –  
ACUTE MENTAL ILLNESS AND CHRONIC MENTAL ILLNESS

Section

- 1110.710 Introduction (Repealed)
- 1110.720 Acute Mental Illness – Definitions (Repealed)
- 1110.730 Acute Mental Illness and Chronic Mental Illness – Review Criteria

SUBPART I: CATEGORY OF SERVICE REVIEW CRITERIA –  
SUBSTANCE ABUSE/ADDICTION TREATMENT

HEALTH FACILITIES AND SERVICES REVIEW BOARD

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Section

- 1110.810 Introduction (Repealed)
- 1110.820 Substance Abuse/Addiction Treatment – Definitions (Repealed)
- 1110.830 Substance Abuse/Addiction Treatment – Review Criteria (Repealed)

SUBPART J: CATEGORY OF SERVICE REVIEW CRITERIA –  
NEONATAL INTENSIVE CARE

Section

- 1110.910 Introduction
- 1110.920 Neonatal Intensive Care – Definitions
- 1110.930 Neonatal Intensive Care – Review Criterion

SUBPART K: CATEGORY OF SERVICE REVIEW CRITERIA –  
BURN TREATMENT

Section

- 1110.1010 Introduction (Repealed)
- 1110.1020 Burn Treatment – Definitions (Repealed)
- 1110.1030 Burn Treatment – Review Criteria (Repealed)

SUBPART L: CATEGORY OF SERVICE REVIEW CRITERIA –  
THERAPEUTIC RADIOLOGY

Section

- 1110.1110 Introduction (Repealed)
- 1110.1120 Therapeutic Radiology – Definitions (Repealed)
- 1110.1130 Therapeutic Radiology – Review Criteria (Repealed)

SUBPART M: CATEGORY OF SERVICE REVIEW CRITERIA –  
OPEN HEART SURGERY

Section

- 1110.1210 Introduction
- 1110.1220 Open Heart Surgery – Definitions
- 1110.1230 Open Heart Surgery – Review Criteria

SUBPART N: CATEGORY OF SERVICE REVIEW CRITERIA –

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CARDIAC CATHETERIZATION

Section

- 1110.1310 Introduction
- 1110.1320 Cardiac Catheterization – Definitions
- 1110.1330 Cardiac Catheterization – Review Criteria

SUBPART O: CATEGORY OF SERVICE REVIEW CRITERIA –  
IN-CENTER HEMODIALYSIS

Section

- 1110.1410 Introduction (Repealed)
- 1110.1420 Chronic Renal Dialysis – Definitions (Repealed)
- 1110.1430 In-Center Hemodialysis Projects – Review Criteria

SUBPART P: CATEGORY OF SERVICE REVIEW CRITERIA –  
NON-HOSPITAL BASED AMBULATORY SURGERY

Section

- 1110.1510 Introduction
- 1110.1520 Non-Hospital Based Ambulatory Surgery – Definitions
- 1110.1530 Non-Hospital Based Ambulatory Surgery – Projects Not Subject to This Part
- 1110.1540 Non-Hospital Based Ambulatory Surgery – Review Criteria

SUBPART Q: CATEGORY OF SERVICE REVIEW CRITERIA –  
COMPUTER SYSTEMS

Section

- 1110.1610 Introduction (Repealed)
- 1110.1620 Computer Systems – Definitions (Repealed)
- 1110.1630 Computer Systems – Review Criteria (Repealed)

SUBPART R: CATEGORY OF SERVICE REVIEW CRITERIA –  
GENERAL LONG TERM CARE

Section

- 1110.1710 Introduction (Repealed)
- 1110.1720 General Long Term Care – Definitions (Repealed)
- 1110.1730 General Long Term Care – Review Criteria (Repealed)

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SUBPART S: CATEGORY OF SERVICE REVIEW CRITERIA –  
SPECIALIZED LONG-TERM CARE

## Section

- 1110.1810 Introduction ([Repealed](#))
- 1110.1820 Specialized Long-Term Care – Definitions ([Repealed](#))
- 1110.1830 Specialized Long-Term Care – Review Criteria ([Repealed](#))

SUBPART T: CATEGORY OF SERVICE REVIEW CRITERIA –  
INTRAOPERATIVE MAGNETIC RESONANCE IMAGING

## Section

- 1110.1910 Introduction (Repealed)
- 1110.1920 Intraoperative Magnetic Resonance Imaging – Definitions (Repealed)
- 1110.1930 Intraoperative Magnetic Resonance Imaging – Review Criteria (Repealed)

SUBPART U: CATEGORY OF SERVICE REVIEW CRITERIA –  
HIGH LINEAR ENERGY TRANSFER (L.E.T.)

## Section

- 1110.2010 Introduction (Repealed)
- 1110.2020 High Linear Energy Transfer (L.E.T.) – Definitions (Repealed)
- 1110.2030 High Linear Energy Transfer (L.E.T.) – Review Criteria (Repealed)

SUBPART V: CATEGORY OF SERVICE REVIEW CRITERIA –  
POSITRON EMISSION TOMOGRAPHIC SCANNING (P.E.T.)

## Section

- 1110.2110 Introduction (Repealed)
- 1110.2120 Positron Emission Tomographic Scanning (P.E.T.) – Definitions (Repealed)
- 1110.2130 Positron Emission Tomographic Scanning (P.E.T.) – Review Criteria (Repealed)

SUBPART W: CATEGORY OF SERVICE REVIEW CRITERIA –  
EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

## Section

- 1110.2210 Introduction (Repealed)
- 1110.2220 Extracorporeal Shock Wave Lithotripsy – Definitions (Repealed)

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

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1110.2230 Extracorporeal Shock Wave Lithotripsy – Review Criteria (Repealed)

SUBPART X: CATEGORY OF SERVICE REVIEW CRITERIA –  
SELECTED ORGAN TRANSPLANTATION

Section

1110.2310 Introduction (Repealed)  
1110.2320 Selected Organ Transplantation – Definitions (Repealed)  
1110.2330 Selected Organ Transplantation – Review Criteria

SUBPART Y: CATEGORY OF SERVICE REVIEW CRITERIA –  
KIDNEY TRANSPLANTATION

Section

1110.2410 Introduction (Repealed)  
1110.2420 Kidney Transplantation – Definitions (Repealed)  
1110.2430 Kidney Transplantation – Review Criteria

SUBPART Z: CATEGORY OF SERVICE REVIEW CRITERIA –  
SUBACUTE CARE HOSPITAL MODEL

Section

1110.2510 Introduction  
1110.2520 Subacute Care Hospital Model – Definitions (Repealed)  
1110.2530 Subacute Care Hospital Model – Review Criteria  
1110.2540 Subacute Care Hospital Model – HFPB Review  
1110.2550 Subacute Care Hospital Model – Project Completion

SUBPART AA: CATEGORY OF SERVICE REVIEW CRITERIA –  
POSTSURGICAL RECOVERY CARE CENTER ALTERNATIVE HEALTH CARE MODEL

Section

1110.2610 Introduction  
1110.2620 Postsurgical Recovery Care Center Alternative Health Care Model – Definitions  
(Repealed)  
1110.2630 Postsurgical Recovery Care Center Alternative Health Care Model – Review  
Criteria  
1110.2640 Postsurgical Recovery Care Center Alternative Health Care Model – HFPB  
Review

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1110.2650 Postsurgical Recovery Care Center Alternative Health Care Model – Project Completion

SUBPART AB: CATEGORY OF SERVICE REVIEW CRITERIA –  
CHILDREN'S COMMUNITY-BASED HEALTH CARE  
CENTER ALTERNATIVE HEALTH CARE MODEL

## Section

1110.2710 Introduction  
1110.2720 Children's Respite Care Center Alternative Health Care Model – Definitions (Repealed)  
1110.2730 Children's Community-Based Health Care Center Alternative Health Care Model – Review Criteria  
1110.2740 Children's Community-Based Health Care Center Alternative Health Care Model – HFPB Review  
1110.2750 Children's Community-Based Health Care Center Alternative Health Care Model – Project Completion

SUBPART AC: CATEGORY OF SERVICE REVIEW CRITERIA –  
COMMUNITY-BASED RESIDENTIAL REHABILITATION CENTER  
ALTERNATIVE HEALTH CARE MODEL

## Section

1110.2810 Introduction  
1110.2820 Community-Based Residential Rehabilitation Center Alternative Health Care Model - Definitions (Repealed)  
1110.2830 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Review Criteria  
1110.2840 Community-Based Residential Rehabilitation Center Alternative Health Care Model – State Board Review  
1110.2850 Community-Based Residential Rehabilitation Center Alternative Health Care Model – Project Completion

SUBPART AD: CATEGORY OF SERVICE REVIEW  
CRITERIA – LONG TERM ACUTE CARE HOSPITAL BED PROJECTS

## Section

1110.2930 Long Term Acute Care Hospital Bed Projects – Review Criteria

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SUBPART AE: CLINICAL SERVICE AREAS OTHER THAN  
CATEGORIES OF SERVICE – REVIEW CRITERIA

Section  
1110.3030 Clinical Service Areas Other Than Categories of Service – Review Criteria

SUBPART AG: CATEGORY OF SERVICE REVIEW CRITERIA –  
FREESTANDING EMERGENCY CENTER MEDICAL SERVICES

Section  
1110.3210 Introduction  
1110.3230 Freestanding Emergency Center Medical Services – Review Criteria

1110.APPENDIX A Medical Specialty Eligibility/Certification Boards  
1110.APPENDIX B State Guidelines – Square Footage and Utilization  
1110.APPENDIX C Statutory Citations for All State and Federal Laws and Regulations  
Referenced in Chapter 3

AUTHORITY: Implementing and authorized by the Illinois Health Facilities Planning Act [20 ILCS 3960].

SOURCE: Fourth Edition adopted at 3 Ill. Reg. 30, p. 194, effective July 28, 1979; amended at 4 Ill. Reg. 4, p. 129, effective January 11, 1980; amended at 5 Ill. Reg. 4895, effective April 22, 1981; amended at 5 Ill. Reg. 10297, effective September 30, 1981; amended at 6 Ill. Reg. 3079, effective March 8, 1982; emergency amendments at 6 Ill. Reg. 6895, effective May 20, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 11574, effective September 9, 1982; Fifth Edition adopted at 7 Ill. Reg. 5441, effective April 15, 1983; amended at 8 Ill. Reg. 1633, effective January 31, 1984; codified at 8 Ill. Reg. 18498; amended at 9 Ill. Reg. 3734, effective March 6, 1985; amended at 11 Ill. Reg. 7333, effective April 1, 1987; amended at 12 Ill. Reg. 16099, effective September 21, 1988; amended at 13 Ill. Reg. 16078, effective September 29, 1989; emergency amendments at 16 Ill. Reg. 13159, effective August 4, 1992, for a maximum of 150 days; emergency expired January 1, 1993; amended at 16 Ill. Reg. 16108, effective October 2, 1992; amended at 17 Ill. Reg. 4453, effective March 24, 1993; amended at 18 Ill. Reg. 2993, effective February 10, 1994; amended at 18 Ill. Reg. 8455, effective July 1, 1994; amended at 19 Ill. Reg. 2991, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 7981, effective May 31, 1995, for a maximum of 150 days; emergency expired October 27, 1995; emergency amendment at 19 Ill. Reg. 15273, effective October 20, 1995, for a maximum of 150 days; recodified from the Department of Public Health to the Health Facilities Planning Board at 20 Ill. Reg. 2600; amended at 20 Ill. Reg. 4734, effective March 22, 1996; amended at 20 Ill. Reg.

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14785, effective November 15, 1996; amended at 23 Ill. Reg. 2987, effective March 15, 1999; amended at 24 Ill. Reg. 6075, effective April 7, 2000; amended at 25 Ill. Reg. 10806, effective August 24, 2001; amended at 27 Ill. Reg. 2916, effective February 21, 2003; amended at 32 Ill. Reg. 12332, effective July 18, 2008; amended at 33 Ill. Reg. 3312, effective February 6, 2009; amended at 34 Ill. Reg. 6121, effective April 13, 2010; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

SUBPART R: CATEGORY OF SERVICE REVIEW CRITERIA –  
GENERAL LONG TERM CARE

**Section 1110.1730 General Long Term Care – Review Criteria (Repealed)**

a) **Introduction**

- 1) ~~This Section applies to projects involving General Long Term Care. Applicants proposing to establish, expand or modernize General Long Term Care category of service shall comply with the applicable subsections of this Section, as follows:~~

PROJECT TYPE	REQUIRED REVIEW CRITERIA
Establishment of Services or Facility	<del>(b)(1)– Planning Area Need—77 Ill. Adm. Code 1100 (formula calculation)</del>
	<del>(b)(2)– Planning Area Need—Service to Planning Area Residents</del>
	<del>(b)(3)– Planning Area Need—Service Demand—Establishment of General Long Term Care</del>
	<del>(b)(5)– Planning Area Need—Service Accessibility</del>
	<del>(e)(1)– Unnecessary Duplication of Services</del>
	<del>(e)(2)– Maldistribution</del>
	<del>(e)(3)– Impact of Project on Other Area Providers</del>
	<del>(g)– Staffing Availability</del>
	<del>(h)– Facility Size</del>
	<del>(i)– Community Related Functions</del>
	<del>(j)– Zoning</del>
<del>(k)– Assurances</del>	

HEALTH FACILITIES AND SERVICES REVIEW BOARD

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Expansion of Existing Services	(b)(2)= Planning Area Need—Service to Planning Area Residents
	(b)(4)= Planning Area Need—Service Demand—Expansion of General Long Term Care
	(g)= Staffing Availability
	(h)= Facility Size
	(k)= Assurances
General Long Term Care Modernization	(f)(1)= Deteriorated Facilities
	(f)(2) & (3)= Documentation
	(f)(4)= Utilization
	(h)= Facility Size
	(i)= Community Related Functions
	(j)= Zoning
Continuum of Care—Establishment or Expansion	(e)(1) & (2)= Description of Continuum of Care Components
	(e)(3)= Documentation
	(g)= Staffing Availability
	(h)= Facility Size
	(i)= Community Related Functions
	(j)= Zoning
	(k)= Assurances
Defined Population—Establishment or Expansion	(d)(1)= Description of Defined Population to be Served
	(d)(2)= Documentation of Need
	(g)= Staffing Availability
	(h)= Facility Size
	(i)= Community Related Functions
	(j)= Zoning
(k)= Assurances	

- 2) If the proposed project involves the replacement of a facility or service onsite, the applicant shall comply with the requirements listed in subsection (a)(1) for "Category of Service Modernization" plus subsection (k) (Assurances).

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- 3) ~~If the proposed project involves the replacement of a facility or service on a new site, the applicant shall comply with the requirements of subsection (a)(1) for "Establishment of Services or Facility".~~
  - 4) ~~If the proposed project involves the replacement of a facility or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for "Expansion of Existing Services".~~
- b) ~~Planning Area Need – Review Criterion~~  
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:
- 1) ~~77 Ill. Adm. Code 1100 (formula calculation)~~
    - A) ~~The number of beds to be established for general long term care is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.~~
    - B) ~~The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.~~
  - 2) ~~Service to Planning Area Residents~~
    - A) ~~Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.~~
    - B) ~~Applicants proposing to add beds to an existing general long term care service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects,~~

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~~applicants shall document that at least 50% of the projected patient volume will be from residents of the area.~~

- ~~C) Applicants proposing to expand an existing general long term care service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).~~

- 3) ~~Service Demand—Establishment of General Long Term Care~~  
The number of beds proposed to establish a new general long term care service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new long term care (LTC) facility, the applicant shall submit projected referrals. The applicant shall document subsection (b)(3)(A) and subsection (b)(3)(B) or (C).

- A) ~~Historical Referrals~~  
If the applicant is an existing facility and is proposing to establish this category of service, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years. Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient LTC facility.

- B) ~~Projected Referrals~~  
An applicant proposing to establish a category of service or establish a new LTC facility shall submit the following:
- i) ~~Hospital referral letters that attest to the number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;~~
  - ii) ~~An estimated number of patients the hospital will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the hospital's experienced LTC caseload;~~

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- iii) ~~Each referral letter shall contain the Chief Executive Officer's notarized signature, the typed or printed name of the referral resources, and the referral resource's address; and~~
- iv) ~~Verification by the hospital that the patient referrals have not been used to support another pending or approved CON application for the subject services.~~
- ↻) ~~Projected Service Demand – Based on Rapid Population Growth~~  
~~If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:~~
  - i) ~~The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;~~
  - ii) ~~Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;~~
  - iii) ~~Projections shall be for a maximum period of 10 years from the date the application is submitted;~~
  - iv) ~~Historical data used to calculate projections shall be for a number of years no less than the number of years projected;~~
  - v) ~~Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;~~
  - vi) ~~Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPB, for each category of service in the application; and~~

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- ~~vii) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPP.~~
- 4) ~~Service Demand—Expansion of Bed Category of Service~~

The number of beds to be added at an existing facility is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

  - A) ~~Historical Service Demand~~
    - ~~i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.~~
    - ~~ii) If prospective residents have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including completed applications that could not be accepted due to lack of the subject service and documentation from referral sources, with identification of those patients by initials and date.~~
  - B) ~~Projected Referrals~~

The applicant shall provide the following:

    - ~~i) Letters from referral sources (hospitals, physicians, social services and others) that attest to total number of prospective residents (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application. Referral sources shall verify their projections and the methodology used;~~
    - ~~ii) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility~~

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- ~~within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources' documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;~~
- ~~iii) Each referral letter shall contain the referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and~~
  - ~~iv) Verification by the referral sources that the prospective resident referrals have not been used to support another pending or approved CON application for the subject services.~~
- C) ~~Projected Service Demand—Based on Rapid Population Growth~~  
~~If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:~~
- ~~i) The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract;~~
  - ~~ii) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH;~~
  - ~~iii) Projections shall be for a maximum period of 10 years from the date the application is submitted;~~
  - ~~iv) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;~~

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- v) ~~Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;~~
  - vi) ~~Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFPPB, for each category of service in the application; and~~
  - vii) ~~Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFPPB.~~
- 5) ~~Service Accessibility~~  
~~The number of beds being established or added for each category of service is necessary to improve access for planning area residents.~~
- A) ~~Service Restrictions~~  
~~The applicant shall document that at least one of the following factors exists in the planning area, as applicable:~~
- i) ~~The absence of the proposed service within the planning area;~~
  - ii) ~~Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;~~
  - iii) ~~Restrictive admission policies of existing providers;~~
  - iv) ~~The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;~~



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~~there is a documented demand for the housing, and that the licensed beds will not be built first, but will be built concurrently with or after the residential units.~~

- 3) ~~The applicant shall provide the following:~~
  - A) ~~That the proposed number of beds is needed. Documentation shall consist of a list of available patients/residents needing the proposed project. The proposed number of beds shall not exceed one licensed LTC bed for every five apartments or independent living units;~~
  - B) ~~Provision in the facility's written operational policies assuring that a resident of the retirement community who is transferred to the LTC facility will not lose his/her apartment unit or be transferred to another LTC facility solely because of the resident's altered financial status or medical indigency; and~~
  - C) ~~That admissions to the long term care unit will be limited to current residents of the independent living units and/or congregate housing.~~
- d) **Defined Population**

The applicant proposing a project for a defined population shall provide the following:

  - 1) ~~The applicant shall document that the proposed project will service a defined population group of a religious, fraternal or ethnic nature from throughout the entire health service area or from a larger geographic service area (referred to in this subsection (d) as the GSA) proposed to be served and that includes, at a minimum, the entire health service area in which the facility is or will be physically located.~~
  - 2) ~~The applicant shall document each of the following:~~
    - A) ~~A description of the proposed religious, fraternal or ethnic group proposed to be served;~~
    - B) ~~The boundaries of the GSA;~~

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- ~~C) The number of individuals in the defined population who live within the proposed GSA, including the source of the figures;~~
  - ~~D) That the proposed services do not exist in the GSA where the facility is or will be located;~~
  - ~~E) That the services cannot be instituted at existing facilities within the GSA in sufficient numbers to accommodate the group's needs. The applicant shall specify each proposed service that is not available in the GSA's existing facilities and the basis for determining why that service could not be provided.~~
  - ~~F) That at least 85% of the residents of the facility will be members of the defined population group. Documentation shall consist of a written admission policy insuring that the requirements of this subsection (d)(2)(F) will be met.~~
  - ~~G) That the proposed project is either directly owned, sponsored or affiliated with the religious, fraternal or ethnic group that has been defined as the population to be served by the project. The applicant shall provide legally binding documents that prove ownership, sponsorship or affiliation.~~
- e) ~~Unnecessary Duplication/Maldistribution – Review Criterion~~
- ~~1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:~~
    - ~~A) A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;~~
    - ~~B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and~~
    - ~~C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the~~

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~~project site that provide the categories of bed service that are proposed by the project.~~

- ~~2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:
  - ~~A) A ratio of beds to population that exceeds one and one-half times the State average;~~
  - ~~B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100; or~~
  - ~~C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.~~~~
- ~~3) The applicant shall document that, within 24 months after project completion, the proposed project:
  - ~~A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and~~
  - ~~B) Will not lower, to a further extent, the utilization of other area facilities that are currently (during the latest 12-month period) operating below the occupancy standards.~~~~
- f) ~~Category of Service Modernization~~
  - ~~1) If the project involves modernization of a category of hospital facility bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:
    - ~~A) High cost of maintenance;~~~~

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- B) ~~Non-compliance with licensing or life safety codes;~~
  - C) ~~Changes in standards of care (e.g., private versus multiple bed rooms); or~~
  - D) ~~Additional space for diagnostic or therapeutic purposes.~~
- 2) ~~Documentation shall include the most recent:~~
- A) ~~IDPH CMMS inspection reports; and~~
  - B) ~~Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports.~~
- 3) ~~Other documentation shall include the following, as applicable to the factors cited in the application:~~
- A) ~~Copies of maintenance reports;~~
  - B) ~~Copies of citations for life safety code violations; and~~
  - C) ~~Other pertinent reports and data.~~
- 4) ~~Projects involving the replacement or modernization of a category of service or facility shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.~~
- g) ~~Staffing Availability—Review Criterion~~  
~~The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.~~
- h) ~~Performance Requirements—Facility Size~~  
~~The maximum size of a general long term care facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient care and documents provision of quality care based on the experience of the~~

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~~applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c – Long Term Care Facilities) over a two-year period of time.~~

- i) ~~Community Related Functions – Review Criterion~~  
~~The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from such organizations.~~
- j) ~~Zoning – Review Criterion~~  
~~The applicant shall document one of the following:~~
  - 1) ~~The property to be utilized has been zoned for the type of facility to be developed;~~
  - 2) ~~Zoning approval has been received; or~~
  - 3) ~~A variance in zoning for the project is to be sought.~~
- k) ~~Assurances~~
  - 1) ~~The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.~~
  - 2) ~~For beds that have been approved based upon representations for continuum of care (subsection (c)) or defined population (subsection (d)), the facility shall provide assurance that it will maintain admissions limitations as specified in those subsections for the life of the facility. To eliminate or modify the admissions limitations, prior approval of HFPB will be required.~~

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

SUBPART S: CATEGORY OF SERVICE REVIEW CRITERIA –

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## SPECIALIZED LONG-TERM CARE

**Section 1110.1810 Introduction (Repealed)**

~~Subpart S contains Review Criteria which pertain to the Specialized Long Term Care Category of Service. These Review Criteria are utilized in addition to the "General Review Criteria" outlined in Subpart C and any other applicable Review Criteria outlined in Subparts D and E. These review criteria shall apply to all specialized long term care projects in the review process, at the time they become effective, and to all subsequent applications relating to specialized long term care.~~

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

**Section 1110.1820 Specialized Long-Term Care – Definitions (Repealed)**

~~"Specialized Long Term Care" means a classification consisting of categories of service which provides inpatient care primarily for children (ages 0 through 21) or inpatient care for adults who require specialized treatment and care because of mental or developmental disabilities. The Specialized Long Term Care Classification includes the following Categories of Services:~~

~~Chronic Mental Illness (M.I.) Category of Service. The Chronic Mental Illness (M.I.) Category of Service includes levels of care provided to severely mentally ill clients in a structured setting in a psychiatric unit of a general hospital, in a private psychiatric hospital, or in a state-operated facility primarily in order to facilitate the improvement of their functioning level, to prevent further deterioration of their functioning level, or, in some instances to maintain their current level of functioning.~~

~~Long Term Care for the Developmentally Disabled (Adult) Category of Service. This Category of Service includes levels of care for Developmentally Disabled adults as defined in the Illinois Mental Health and Developmental Disabilities Code (including those facilities licensed as ICF/DD or Intermediate Care Facilities for the Developmentally Disabled) which provide an integrated, individually tailored program of services for developmentally disabled adults and which provides an active, aggressive, and organized program of services directed toward achieving measurable behavioral and learning objectives.~~

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~~Long-Term Care for the Developmentally Disabled (Children) Category of Service. This Category of Service includes levels of care for Developmentally Disabled Children and is limited to those residents ages 0 through 21 years and whose condition meets the definition of "Developmental Disabilities" (as defined in the Illinois Mental Health and Developmental Disabilities Code).~~

~~Long-Term Medical Care for Children Category of Service. The Long-Term Medical Care For Children Category of Service includes long-term medical services which are provided to those patients/residents ages 0-18 years and which provides for residents suffering from chronic medical disabilities.~~

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

**Section 1110.1830 Specialized Long-Term Care – Review Criteria (Repealed)**

- a) ~~Facility Size—Review Criterion. The maximum unit size is 100 beds, unless the project is for a State-operated facility or for the long-term medical care for children Category of Service.~~
- b) ~~Community Related Functions—Review Criterion. The applicant must document the written endorsement of community groups including the following:
  - 1) ~~a detailed description of the steps taken to inform and receive input from the public, including those community members who live in close proximity to the proposed facility's location;~~
  - 2) ~~endorsements from social service, social, and economic organizations; and~~
  - 3) ~~support from municipal officials and other elected officials representing the area in which the proposed facility is located.~~~~
- e) ~~Availability of Ancillary and Support Programs—Review Criterion. An applicant proposing the establishment of an ICF/DD facility of 16 beds or fewer must document that the community has the necessary support services available to provide care to the proposed facility's residents. Such documentation must include:~~

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- 1) ~~a copy of the letter, sent by certified mail, return receipt requested, to each of the day programming programs in the area informing them of the proposed project and requesting their comments regarding the impact of the proposed project upon their programs. The applicant shall also provide copies of the responses received from these letters;~~
  - 2) ~~a description of the transportation services available to the proposed residents;~~
  - 3) ~~a description of the specialized services, other than day programming, available to the proposed residents;~~
  - 4) ~~a description of the availability of community activities for the proposed facility's residents, e.g., movie theaters, bowling alleys, etc.; and~~
  - 5) ~~documentation of the availability of a community workshop to serve the residents.~~
- d) ~~Recommendations from State Departments — Review Criterion. An applicant proposing a facility for the developmentally disabled must document contact with the Department of Human Services and the Department of Public Aid. Documentation must include proof that a request has been submitted to each Department requesting that each Department determine the project's consistency with the long-range goals and objectives of the Department and requesting the identification of individuals in need of the service. The Departments' responses should address, on both a Statewide and a planning area basis, whether the proposed project meets the Department's planning objectives regarding the size, type, and number of beds proposed, whether the project conforms or does not conform to each Department's plan, and how the project assists or hinders each Department in achieving its planning objectives. Such a request must be made by certified mail return receipt requested and must occur within a 60-day period prior to the submission of this application.~~
- e) ~~Long-Term Medical Care for Children Category of Service (Only) — Review Criterion. The applicant must document the following:~~
- 1) ~~the planning area served by the facility and the size of the specialized population ages 0-18 years to be served within that geographic area. Documentation must include, but is not limited to, any reports or studies~~

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- ~~showing the points of origin of patients/residents admitted to the facility, preferably for the latest 12 month period for which data is available;~~
- ~~2) identification of the special programs and/or services to be provided or currently offered by the applicant and the relationship of such programs to the needs of the specialized population (as outlined above);~~
  - ~~3) insufficient service capability currently exists to meet this need; and~~
  - ~~4) the number of beds in the proposed project is needed by providing documentation that the proposed project will achieve, within the first year of operation, an occupancy of at least 90 percent.~~
- f) ~~Zoning—Review Criterion. The applicant must document that:~~
- ~~1) the property to be utilized has been zoned for the type of facility to be developed; or~~
  - ~~2) zoning approval has been received; or~~
  - ~~3) a certificate of need is required by the local zoning authority before zoning can be approved. Such documentation shall include a letter from the appropriate zoning official indicating that such a requirement exists.~~
- g) ~~Establishment of Chronic Mental Illness—Review Criterion. Documentation shall consist of a narrative statement detailing the scope of system changes which have brought about the need for the project and historical utilization of facilities involved. The applicant must document that:~~
- ~~1) all beds will be operated by the State of Illinois;~~
  - ~~2) the resident population and type of resident/patient served has changed, necessitating the establishment or expansion of services in order to meet the needs of the facility's residents;~~
  - ~~3) the project represents redistribution of existing beds from another facility due to closure of the facility or unit; and~~
  - ~~4) admissions from the general public have increased over the last two year~~

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~~period and the expansion is necessary in order to adequately serve the residents of the facility and the general public.~~

- ~~h) Establishment of Beds, Developmentally Disabled (Adult) Category of Service—Review Criterion. Any proposed project to establish a facility of 16 beds or fewer must be located in a planning area where a need for additional beds is calculated using the formula shown in 77 Ill. Adm. Code 1100.670, unless the applicant can document compliance with the requirements for a variance to the computed bed need in subsection (i) of this Section.~~
- ~~i) Variance to Computed Bed Need for Establishment of Beds, Developmentally Disabled (Adult) Category of Service, for Placement of Residents From Department of Human Services (DHS) Operated Beds—Review Criterion. The applicant must document all of the following:
  - ~~1) That each of the residents proposed to be served:
    - ~~A) currently resides in a DHS-operated facility and has at least one interested family member residing in the proposed planning area; or has an interested family member who resides out of state within 15 miles of the proposed planning area boundary; or~~
    - ~~B) has resided in a DHS-operated facility physically located in the proposed project's planning area for at least the last 2 years, and the consent of the resident's legal guardian has been obtained for the relocation.~~~~
  - ~~2) All of the existing 16-bed or fewer facilities in the planning area are occupied at or above the 93% target occupancy rate or such facilities have refused to accept residents referred from DHS-operated facilities. Documentation of each refusal must include the following:
    - ~~A) a letter from DHS stating the number of times in the last 12 months the facility or facilities have refused to accept referrals of DHS-operated facility residents, including the name of the facility, the date of the refusal, and the reason(s) cited for such refusals, if any;~~
    - ~~B) a copy of the letter, sent by certified mail return receipt requested, to each of the underutilized facilities in the area asking if they~~~~~~

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- ~~accept referrals from DHS-operated facilities, listing the dates of each past refusal, and requesting an explanation of the basis for the refusal in each instance;~~
- ~~C) copies of the responses to the above letters; and~~
- ~~D) a letter from DHS indicating that each of the residents to be referred to the proposed facility have been refused admission at all of the other 16 bed or fewer facilities in the planning area.~~
- ~~3) That the proposed relocation of a resident will result in cost savings to the State.~~
- ~~4) That the facility will only accept future referrals from the DHS-operated facility in the planning area if a bed is available.~~
- ~~5) An explanation of how the proposed facility conforms with or deviates from the DHS comprehensive long range development plan for developmental disabilities services.~~
- ~~j) State Board Consideration of Public Hearing Testimony—Review Criterion.—If public hearing testimony is presented that indicates that one or more facilities in the planning area have available beds, and are willing to accept DHS referrals, IDPH shall notify DHS and request that DHS contact the facility or facilities and attempt to place residents in such beds, thereby reducing the need for the proposed additional beds. DHS shall notify IDPH of the results of these placement efforts within 45 days after the date of IDPH advice. If DHS' response is not received by IDPH within the specified time period, IDPH shall assume that the patients were placed appropriately and that the need for such additional beds no longer exists. If the existing facility(ies) refuses to accept such referrals, IDPH shall be notified by DHS of the refusal and of any rationale for the refusal provided to DHS by the refusing facility. This material shall then be forwarded to the Board for its consideration. The review period set forth in 77 Ill. Adm. Code 1130.610(b) may be extended by IDPH for a period not to exceed 60 days.~~

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

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- 1) Heading of the Part: Long-Term Care
- 2) Code Citation: 77 Ill. Adm. Code 1125
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1125.110	New
1125.120	New
1125.130	New
1125.140	New
1125.210	New
1125.220	New
1125.310	New
1125.320	New
1125.330	New
1125.510	New
1125.520	New
1125.530	New
1125.540	New
1125.550	New
1125.560	New
1125.570	New
1125.580	New
1125.590	New
1125.600	New
1125.610	New
1125.620	New
1125.630	New
1125.640	New
1125.650	New
1125.710	New
1125.720	New
1125.730	New
1125.800	New
1125.APPENDIX A	New
1125.APPENDIX B	New
- 4) Statutory Authority: Illinois Health Facilities Planning Act [20 ILCS 3960]

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- 5) A Complete Description of the Subjects and Issues Involved: The Health Facilities Planning Act [20 ILCS 3960/12] mandates the establishment of a separate set of rules and guidelines pertaining to long-term care (LTC). The proposed rules will establish 77 Ill. Adm. Code 1125, consolidating the definitions, planning policies, review criteria, and standards for General Long-Term Care, as well as Specialized Long-Term Care.

Existing long-term care rules currently housed in 77 Ill. Adm. Code 1100 and 1110 will be relocated to the new 77 Ill. Adm. Code 1125. Applicable Sections from 77 Ill. Adm. Code 1120 (Financial and Economic Feasibility) are also included in the proposed set of rules. In addition, HFSRB Procedural rules (77 Ill. Adm. Code 1130) are referenced as part of the consolidation. Substantive changes to the rules are summarized below:

Statutory Authority:

Section 1125.110(d), the purpose of the mandated LTC Advisory Subcommittee is cited.

Definitions:

Section 1125.140 contains existing definitions that pertain to Long-Term Care (includes updates per the Act), as well as definitions applicable in general.

Project Purpose, Background and Alternatives – Information Requirements:

In the existing rules (Section 1110.230), "Background of the Applicant" is located in this Section as a general information requirement. The proposed rules relocate this consideration to Section 1125.520 – General Long Term Care – Review Criteria.

General Long-Term Care – Review Criteria:

As indicated above, "Background of the Applicant" is relocated to Section 1125.520, changing the review status from a general information requirement to a review criterion.

"Variances to Computed Bed Need" returns as a subcategory of LTC project types, located in Section 1125.560. This Section includes (2) variances from the language of existing rules: "Continuum of Care"; and "Defined Population".

Existing Sections related to LTC and housed in 77 Ill. Adm. Codes 1100 and 1110 will be repealed.

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- 6) Published studies or reports, and sources of underlying data used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b)].
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Public Hearing  
to be conducted on  
May 18, 2011  
10:00 a.m. – 2:00 p.m.  
Oak Forest City Council Chambers  
15440 S. Central Avenue  
Oak Forest, Illinois

Interested persons may present their comments concerning this rulemaking within 45 days after the publication of this issue of the Illinois Register to:

Claire Burman  
Coordinator, Rules Development  
Illinois Health Facilities and Services Review Board  
122 S. Michigan Avenue, 7<sup>th</sup> Floor  
Chicago, Illinois 60603

312/814-4825  
e-mail: [Claire.Burman@illinois.gov](mailto:Claire.Burman@illinois.gov)

- 13) Initial Regulatory Flexibility Analysis:

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- A) Types of small businesses, small municipalities and not for profit corporations affected: Long-term care facilities
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent Regulatory Agendas because: the need for the rulemaking was not apparent when the Regulatory Agenda was prepared.

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

HEALTH FACILITIES AND SERVICES REVIEW BOARD

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TITLE 77: PUBLIC HEALTH  
CHAPTER II: HEALTH FACILITIES AND SERVICES REVIEW BOARD  
SUBCHAPTER b: OTHER BOARD RULES

PART 1125  
LONG-TERM CARE

SUBPART A: AUTHORITY

Section	
1125.110	Statutory Authority
1125.120	Introduction
1125.130	Purpose
1125.140	Definitions
1125.150	HFSRB Procedural Rules

SUBPART B: PLANNING POLICIES

Section	
1125.210	General Long-Term Nursing Care Category of Service
1125.220	Specialized Long-Term Care Categories of Service

SUBPART C: GENERAL INFORMATION REQUIREMENTS

Section	
1125.310	Introduction
1125.320	Purpose of the Project – Information Requirements
1125.330	Alternatives to the Proposed Project – Information Requirements

SUBPART D: GENERAL LONG-TERM CARE – REVIEW CRITERIA

Section	
1125.510	Introduction
1125.520	Background of the Applicant – Review Criterion
1125.530	Planning Area Need – Review Criterion
1125.540	Service Demand – Establishment of General Long-Term Care
1125.550	Service Demand – Expansion of General Long-Term Care
1125.560	Variances to Computed Bed Need
1125.570	Service Accessibility

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1125.580	Unnecessary Duplication/Maldistribution
1125.590	Staffing Availability
1125.600	Bed Capacity
1125.610	Community Related Functions
1125.620	Project Size – Review Criterion
1125.630	Zoning
1125.640	Assurances
1125.650	Modernization

## SUBPART E: SPECIALIZED LONG-TERM CARE – REVIEW CRITERIA

## Section

1125.710	Introduction
1125.720	Specialized Long-Term Care – Review Criteria

## SUBPART F: FINANCIAL AND ECONOMIC FEASIBILITY – REVIEW CRITERIA

## Section

1125.800	Estimated Total Project Cost
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1125.APPENDIX A Project Size Standards – Square Footage and Utilization

1125.APPENDIX B Financial and Economic Review Standards

AUTHORITY: Authorized by Section 12 of and implementing the Illinois Health Facilities Planning Act [20 ILCS 3960].

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

## SUBPART A: AUTHORITY

**Section 1125.110 Statutory Authority**

- a) This Part is promulgated by authority granted to the Illinois Health Facilities and Services Review Board under the Illinois Health Facilities Planning Act [20 ILCS 3960].
- b) After the effective date of this Part, all applications in the review process and all projects for which permits or exemptions have been issued, but have not yet been completed, shall be subject to this Part.

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- c) The HFSRB rules in effect on the date of alleged violation of the Act or rules shall be applicable concerning all considerations and issues of compliance with HFSRB requirements.
- d) Advisory Subcommittee
  - 1) The Long-term Care Facility Advisory Subcommittee is created by the Act to:
    - A) *Develop and recommend to the Board a separate set of rules and guidelines for long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities; and*
    - B) *Provide continuous review and commentary on policies and procedures relative to long-term care and the review of related projects.*
  - 2) *The Subcommittee shall be provided a reasonable and timely opportunity to review and comment on any review, revision, or updating of the criteria, standards, procedures, and rules used to evaluate project applications as provided under Section 12.3 of the Act prior to approval by the Board and promulgation of related rules. [20 ILCS 3960/12(15)]*

**Section 1125.120 Introduction**

This Part has been developed, per the Act, for projects involving the establishment, expansion or modernization of general long-term care facilities and specialized long-term care facilities and establishes the procedures and requirements for processing and review of applications for permits, applications for exemption and other matters that are subject to the Act and to determinations by HFSRB. This Part pertains to, but is not limited to, persons and transactions subject to the Act; the requirements for submission of applications for permits or exemptions; the HFSRB review process; public hearing procedures for applications and proposed rules; requirements for maintaining valid permits; declaratory rulings; and administrative hearings.

**Section 1125.130 Purpose**

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- a) *The purpose of the Act is to establish a procedure designed to reverse the trends of increasing costs of health care, including long-term care, resulting from unnecessary construction of health care facilities. This program is established to:*
- 1) *improve the financial ability of the public to obtain necessary health services, establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public;*
  - 2) *maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent;*
  - 3) *assure that the reduction and closure of health care services or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public; and*
  - 4) *assess the financial burden to patients/residents caused by unnecessary health care construction and modification. [20 ILCS 3960/2]*
- b) Decisions regarding proposed new health services and facilities shall be made for reasons having to do with the community health needs in the various parts of the State. The burden of proof on all issues pertaining to an application shall be on the applicant.
- c) The health facilities and services review program shall be administered with the goal of maximizing the efficiency of capital investment and the objectives of:
- 1) Promoting development of more effective methods of delivering long-term care;
  - 2) Improving distribution of LTC facilities and services and ensuring access to needed LTC services for the general public, the medically indigent and similar underserved populations;
  - 3) Controlling the increase of LTC costs;
  - 4) Promoting planning for LTC services at the facility, regional and State levels;

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- 5) Maximizing the use of existing LTC facilities and services that represent the least costly and most appropriate levels of care; and
- 6) Minimizing the unnecessary duplication of LTC facilities and services.

**Section 1125.140 Definitions**

"Act" means the Illinois Health Facilities Planning Act [20 ILCS 3960].

"Adverse Action" means a disciplinary action taken by Department of Public Health, Centers for Medicare and Medicaid Services (CMMS), or any other State or federal agency against a person or entity that owns and/or operates a licensed or Medicare or Medicaid certified LTC facility in the State of Illinois. These actions include, but are not limited to, all Type A and Type AA violations. As defined in Section 1-129 of the Nursing Home Care Act [210 ILCS 45], a *"Type A violation"* means a violation of the Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that the risk of death or serious mental or physical harm to a resident will result therefrom or has resulted in actual physical or mental harm to a resident. As defined in Section 1-128.5 of the Nursing Home Care Act, a *"Type AA violation"* means a violation of the Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility that proximately caused a resident's death.

"Agency" or "IDPH" means the Illinois Department of Public Health.

"Applicant" means one or more persons, as defined in the Act, who apply for a permit or exemption. See 77 Ill. Adm. Code 1130.220 to determine what parties are necessary for an application.

"Authorized Representative" means a person who has authority to act on behalf of the legal entity or person that is the applicant or permit holder. Authorized representatives are: in the case of a corporation, any of its officers or members of its board of directors; in the case of a limited liability company, any of its managers or members (or the sole manager or member when two or more managers or members do not exist); in the case of a partnership, any of its general partners (or the sole general partner when two or more general partners do not

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exist); in the case of estates and trusts, any of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and in the case of a sole proprietor, the individual who is the proprietor.

"Capital Expenditure" means an expenditure made by or on behalf of an LTC facility (as such a facility is defined in the Act), which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part and which exceeds the capital expenditure minimum. For purposes of this definition, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditure minimum. Donations of equipment or facilities to an LTC facility which if acquired directly by such facility would be subject to review under the Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure if a transfer of the equipment or facilities at fair market value would be subject to review. [20 ILCS 3960/3]

"Capital Expenditure Minimum" means the dollar amount or value that would require a permit for capital projects and major medical equipment. Capital expenditure minimums are annually adjusted to reflect the increase in construction costs due to inflation under 77 Ill. Adm. Code 1130.310.

"Category of Service" means a grouping by generic class of various types or levels of support functions, equipment, care or treatment provided to patients/residents. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service.

"CMMS" means the federal Centers for Medicare and Medicaid Services.

"Chairman" means the presiding officer of HFSRB.

"Change of Ownership" means a change in the person who has operational control of an existing LTC facility or a change in the person who has ownership or control of an LTC facility's physical plant and capital assets. A change of ownership is indicated by, but not limited to, the following transactions: sale,

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*transfer, acquisition, leases, change of sponsorship or other means of transferring control.* [20 ILCS 3960/3] Examples of change of ownership include:

a transfer of stock or assets resulting in a person obtaining majority interest (i.e., over 50%) in the person who is licensed or certified (if the facility is not subject to licensure), or in the person who owns or controls the LTC facility's physical plant and capital assets; or

the issuance of a license by IDPH to a person different from the current licensee; or

a change in the membership or sponsorship of a not-for-profit corporation; or

a change of 50% or more of the voting members of a not-for-profit corporation's board of directors, during any consecutive 12 month period, that controls an LTC facility's operations, license, certification (when the facility is not subject to licensing) or physical plant and capital assets; or

a change in the sponsorship or control of the person who is licensed or certified (when the facility is not subject to licensing) to operate, or who owns the physical plant and capital assets of a governmental LTC facility; or

any other transaction that results in a person obtaining control of an LTC facility's operations or physical plant and capital assets, including leases.

"Change in the Bed Count of a Long-Term Care Facility" means a change in an LTC facility's authorized bed capacity, including reductions, increases with permit or allowable increases without permit. *A permit or exemption shall be obtained prior to the construction or modification of an LTC facility which: changes the bed capacity of an LTC facility by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility to another by more than 20 beds or 10% of total bed capacity as defined by the State Board, whichever is less, over a 2-year period.* [20 ILCS 3960/5]

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"Charity Care" means care provided by an LTC facility for which the provider does not expect to receive payment from the patient/resident or a third party payer. [20 ILCS 3960/3]

"Clinical Service Area" means a department and/or service that is directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the LTC facility [20 ILCS 3960/3]. A clinical service area's physical space shall include those components required under the facility's licensure or Medicare and/or Medicaid certification, and/or as outlined by documentation from the facility as to the physical space required for appropriate clinical practice.

"Combined Service Area Project" means a project that consists of both clinical service areas and non-clinical service areas.

"Completion" or "Project Completion" means that the project has been brought to a conclusion as evidenced by one or more of the following events:

For projects with no cost that are limited to a substantial change in beds in licensed LTC facilities, the date IDPH issues a revised license; or

For projects with no cost that are limited to a substantial change in beds in LTC facilities or in State-operated facilities, the date the first patient is treated; or

For projects limited to the establishment of a category of service, the date the first patient is treated; or

For projects limited to the establishment of an LTC facility, the date the LTC facility is licensed or, if licensure is not required, the date the facility receives Medicare/Medicaid certification; or

For all other projects including modernization of existing facilities, project completion occurs when all components of the project are fulfilled as stated in the application for permit or exemption; or

For projects with permits issued with conditions, the date HFSRB deems the conditions have been met.

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"Completion Date" or "Project Completion Date" means the date established by the applicant for the completion of the project in the approval of the permit or subsequent renewal, as evidenced by one or more of the events cited in the definition of "Completion".

"Construction" or "Modification" *means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership of or by an LTC facility, or the purchase or acquisition by or through an LTC facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation or any capital expenditure made by or on behalf of an LTC facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of an LTC facility for the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act [210 ILCS 9] or a conversion project undertaken in accordance with Section 30 of the Older Adult Services Act [320 ILCS 42] shall be excluded from any obligations under the Act. [20 ILCS 3960/3]*

"Contested Case" is defined in Section 1-30 of the Illinois Administrative Procedure Act. [5 ILCS 100/1-30].

"Control" means a person possesses any of the following discretionary and non-ministerial rights or powers:

In the case of an entity, the ability to direct the management and policies of the entity, whether through the voting of securities, corporate membership, contract or otherwise. Examples of control include, without limitation:

holding 50% or more of the outstanding voting securities of an issue;

in the case of an entity that has no outstanding voting securities, having the right to 50% or more of the profits or, in the event of dissolution, the right to 50% or more of the assets of the entity;

having the power to appoint or remove 50% or more of the governing board members of an entity;

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having the power to require or approve the use of funds or assets of the entity; or

having the power to approve, amend or modify the entity's bylaws or other governance documents.

In the case of capital assets or real property, the power to direct or cause the direction of the personal property, real property or capital assets that are components of the project (i.e., fixed equipment, mobile equipment, buildings and portions of buildings). Examples of control include, without limitation:

ownership of 50% or more in the property or asset;

serving as lessee or sub-lessee.

"Conversion" means a change in the control of an existing LTC facility's physical plant, assets, or operations by such methods as, but not limited to, a change in ownership, acquisition, merger, consolidation, lease, stock transfer, or change in sponsorship. Types of conversion include:

consolidation by combining two or more existing LTC facilities into a new LTC facility, terminating the existence of the existing or original facilities ( $A + B = C$ ). Consolidation results in the establishment of an LTC facility within the meaning of the Act and in the discontinuation of the existing facilities, resulting in termination of license for facilities subject to licensing or the loss of certification for facilities not subject to licensing;

merger by the absorption of one or more existing LTC facilities into another existing LTC facility. The result of the absorption is that only one facility survives ( $A + B = B$ ). Merger results in the modification (e.g., expansion of beds or services) of the survivor facility and the discontinuation of the facility being absorbed.

"Director" means the Director of the Department of Public Health.

"Due Diligence" means to take such actions toward the completion of a project for which a permit has been issued with that diligence and foresight that persons of ordinary prudence and care commonly exercise under like circumstances. An

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accidental or unavoidable cause that cannot be avoided by the exercise of due diligence is a cause that reasonably prudent and careful persons, under like circumstances, do not and would not ordinarily anticipate, and whose effects under similar circumstances they do not and would not ordinarily avoid.

"Entity" means any corporation, company, partnership, joint venture, association, trust, foundation, fund or other legally recognized organization, public body or municipality.

"Establish" or "Establishment" *means the construction of a new LTC facility, the licensing of unlicensed buildings or structures as an LTC facility, the replacement of an existing LTC facility on another site, or the initiation of a category of service defined by the Board.* [20 ILCS 3960/3]

"Estimated Project Cost" or "Project Cost" means the sum of all costs, including the fair market value of any equipment or other real property (whether acquired by lease, donation, or gift) necessary to complete a project, including:

- preplanning costs;
- site survey and soil investigation fees;
- site preparation costs;
- off-site work;
- construction contracts and contingencies (including demolition);
- capital equipment included in construction contracts;
- architectural and engineering fees;
- consultants and other professional fees that are related to the project;
- capital equipment not in construction contracts;
- bond issuance expenses;
- net interest expense during construction; and

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all other costs that are to be capitalized.

"Exemption" means the classification of projects that are exempt from the Certificate of Need permit review process, but are reviewed under *the procedures and requirements of HFSRB regarding issuance of exemptions. An exemption shall be approved when information required by the Board by rule is submitted.* [20 ILCS 3960/6(b)]

"Existing Long-Term Care Facility" means any LTC facility subject to the Act that:

has a license issued by IDPH and has provided services within the past 12 months, unless the failure to provide that service is the result of pending license revocation procedures, and has not surrendered or abandoned its license or had its license revoked or voided or otherwise deemed invalid by IDPH; or

is certified under Title XVIII or XIX of the Social Security Act (42 USC 1395); or

is a facility operated by the State of Illinois.

HFSRB NOTE: Projects approved by HFSRB for establishment of an LTC facility that have not been deemed complete in accordance with this Part shall not be considered existing facilities, but the approved number of beds or services shall be recorded in the HFSRB Inventory of Health Care Facilities and Services and Need Determinations, located at the HFSRB website ([www.hfsrb.illinois.gov](http://www.hfsrb.illinois.gov)), and shall be counted against any applicable need estimate.

"Ex parte Communication" *means a communication between a person who is not a State Board member or employee that reflects on the substance of a formally filed State Board proceeding and that takes place outside the record of the proceeding. Communications regarding matters of procedure and practice, such as the format of a pleading, number of copies required, manner of service, and status of proceedings, are not considered ex parte communications. Technical assistance with respect to an application, not intended to influence any decision on the application, may be provided by employees to the applicant. Once an*

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*application is filed and deemed complete, a written record of any communication between staff and an applicant shall be prepared by staff and made part of the public record, using a prescribed, standardized format, and shall be included in the application file. [20 ILCS 3960/4.2]*

"Fair Market Value" means the dollar value of a project or any component of a project that is accomplished by lease, donation, gifts or any other means that would have been required for purchase, construction or acquisition. Fair market value is documented as follows:

for equipment that is to be leased, statements from the manufacturers as to the purchase price of the equipment;

for equipment or other real property that will be a gift or donated, a statement from the donor attesting to the dollar value reported to the Internal Revenue Service pursuant to IRS Document 170;

for existing property (other than equipment) that is to be leased or otherwise acquired, copies of an appraisal performed by a certified appraiser or copies of financial statements detailing actual construction costs if the property is less than three years old; or

for property (other than equipment) that is being or will be constructed and then leased, a statement from the lessor as to the anticipated costs of construction.

"Final Decision" or "Final Administrative Decision" or "Final Determination" means:

the decision by HFSRB to approve or deny an application for permit. Action taken by HFSRB to deny an application for permit is subsequent to an administrative hearing or to the waiver of an administrative hearing; or

the decision by HFSRB on all matters other than the issuance of a permit.

HFSRB NOTE: The decision is final at the close of business of the HFSRB meeting at which the action is taken.

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"Final Realized Costs" means all costs that are normally capitalized under generally accepted accounting principles that have been incurred to complete a project for which a permit or exemption was issued. These costs include all expenditures and the dollar or fair market value of any component of the project, whether acquired through lease, donation or gift.

"Hearing Officer" means the person with authority to conduct public hearings and to take all necessary steps to assure the proper completion of public hearings and to assure compliance with requirements of the Act. Responsibilities include: determining the order and time allotment for public testimony; maintaining order; setting and announcing new hearing dates, times and places, as necessary; determining the conclusion of the hearing and assuring that all documents, exhibits and other written materials presented or requested at the hearing are in the hearing officer's custody; and preparing a report for submittal to HFSRB.

"HFSRB " or "State Board" means the Illinois Health Facilities and Services Review Board.

"HFSRB Inventory" or "Inventory" means the HFSRB Inventory of Health Care Facilities and Services and Need Determinations, located at HFSRB's website ([www.hfsrb.illinois.gov](http://www.hfsrb.illinois.gov)).

"IAPA" means the Illinois Administrative Procedure Act [5 ILCS 100].

"Intent to Deny" means the negative decision of HFSRB, following its initial consideration of an application for permit that failed to receive the number of affirmative votes required by the Act.

"Long-Term Care" or "LTC" means care for patients/residents in a general long-term care or specialized long-term care facility under the jurisdiction of the Board.

General LTC includes the nursing category of service, which provides inpatient treatment for convalescent or chronic disease patients/residents and includes the skilled nursing level of care and/or the intermediate nursing level of care, defined in 77 Ill. Adm. Code 300.

Specialized LTC means a classification of categories of service that provide inpatient care primarily for children (ages 0 through 21) or

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inpatient care for adults who require specialized treatment and care because of mental or developmental disabilities. Specialized LTC includes the following categories of services:

Chronic Mental Illness (MI) Category of Service. The Chronic MI category of service includes levels of care provided to severely mentally ill clients in a structured setting in a psychiatric unit of a general hospital, in a private psychiatric hospital, or in a State-operated facility primarily in order to facilitate the improvement of their functioning level, to prevent further deterioration of their functioning level, or, in some instances, to maintain their current level of functioning.

Long-Term Care for the Developmentally Disabled-Adult (DD-Adult) category of service. This category of service includes levels of care for DD-Adults as defined in the Mental Health and Developmental Disabilities Code [405 ILCS 5] (including those facilities licensed as ICF/DD) that provide an integrated, individually-tailored program of services for developmentally disabled adults and provide an active, aggressive and organized program of services directed toward achieving measurable behavioral and learning objectives.

Long-Term Care for the Developmentally Disabled-Children category of service. This category of service includes levels of care for DD-Children (those residents age 0 through 21 years) as defined in the Illinois Mental Health and Developmental Disabilities Code).

Long-Term Medical Care for Children Category of Service. This category of service includes long-term medical services that are provided to those patients/residents age 0-18 years and that provides for residents suffering from chronic medical disabilities.

"Major Construction Project" means:

*Projects for the construction of new buildings;*

*Additions to existing facilities;*

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*Modernization projects whose cost is in excess of \$1,000,000 or 10% of the facility's operating revenue, whichever is less; and*

*such projects as the State Board shall define and prescribe pursuant to the Act. [20 ILCS 3960/5]*

"Major Medical Equipment" *means medical equipment that is used for the provision of medical and other health services and that costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act (42 USC 1395x) to meet the requirements of section 1861(S)(10) and (11) of that Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of the equipment shall be included. [20 ILCS 3906/3]*

"Medicaid Certified" or "Medicare Certified" or "Medicaid Certification" or "Medicare Certification" means approval for a facility to receive reimbursement under Title XVIII (Medicare) and/or XIX (Medicaid) of the Social Security Act (42 USC 1395).

"Modification of an Application" or "Modification" means any change to an application during the review period (i.e., prior to a final HFSRB action). These changes include, but are not limited to: changing the proposed project's physical size or gross square feet, the site within a planning area, the operating entity when the operating entity is not the applicant, the number of proposed beds, the categories of service to be provided, the cost, the method of financing, the proposed project completion date, the configuration of space within the building, or any change in the person who is the applicant, including the addition or deletion of one or more persons as co-applicants.

HFSRB NOTE: A change of site to a site outside the planning area originally identified in the application is not considered a modification and invalidates the application.

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"Newspaper of General Circulation" means newspapers other than those intended to serve a particular, defined population, such as the publications of professional and trade associations.

"Newspaper of Limited Circulation" means a newspaper intended to serve a particular or defined population of a specific geographic area within a Metropolitan Statistical Area such as a municipality, town, village, township or community area, but does not include publications of professional and trade associations. [20 ILCS 3960/8.5(a)]

"Non-clinical Service Area" *means an area for the benefit of the patients/residents, visitors, staff or employees of an LTC facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the LTC facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient/resident, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

"Non-Substantive Projects" means certain projects that have been defined in 77 Ill. Adm. Code 1110.40, with a review period of 60 days.

"Notification of HFSRB Action" means the transmittal of HFSRB decisions to the applicant or permit or exemption holder. Notification shall be given to the applicant's or permit holder's designated contact person, legal representative or chief executive officer.

"Obligation" means the commitment of at least 33% of total funds assigned to cover total project cost, which occurs by:

The actual expenditure of 33% or more of the total project cost; or

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The commitment to expend 33% or more of the total project cost by signed contracts or other legal means.

"Operational" means that a permit holder is providing the services approved by HFSRB and, for a new LTC facility or a new category of service, licensure or Medicare and/or Medicaid certification has been obtained and residents/patients are utilizing the facility or equipment or are receiving service.

"Permit" means authorization to execute and complete a project related to an LTC facility, as reviewed and approved by HFSRB and as specified in the Act.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof. [20 ILCS 3960/3]

"Project Obligation Date" means the date on which the permit holder expended or committed to expend by contract or other legal means at least 33% of the total project cost.

"Proposal" or "Project" means any proposed construction or modification of an LTC facility or any proposed acquisition of equipment to be undertaken by an applicant.

"Related Person" means any person that:

*is at least 50% owned, directly or indirectly, by either the LTC facility or a person owning, directly or indirectly, at least 50% of the LTC facility; or*

*owns, directly or indirectly, at least 50% of the LTC facility; [20 ILCS 3960/3] or*

*is otherwise controlled or managed by one or more LTC facilities; or*

*controls or manages the LTC facility; or*

*otherwise controls or manages the LTC facility; or*

*is otherwise, directly or indirectly, under common management or control with one or more LTC facilities.*

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"Review Period" means the time from the date an application for permit or exemption is deemed complete until HFSRB renders its final decision.

"Site" means the physical location of a proposed project and is identified by address or legal property description.

"Square Feet" or "SF" or "Square Footage" means a unit of measure of physical service areas or buildings considered by HFSRB. Departmental Gross Square Feet (DGSF) means the designation of physical areas for departments and services. It consists of the entirety of space dedicated to the use of that department or service, including walls, shafts and circulation. Building Gross Square Feet (BGSF) means the designation of physical area of an entire building. It includes all exterior walls and space within those walls.

"Subcommittee" means the HFSRB Long-Term Care Facility Advisory Subcommittee.

"Subcommittee Chairperson" means the chairperson of the Subcommittee.

"Substantially Changes the Scope or Changes the Functional Operation of the Facility" means:

the addition of a category of service;

a change of a material representation made by the applicant in an application for permit or exemption subsequent to receipt of a permit that is relied upon by HFSRB in making its decision. Material representations are those that provide a factual basis for issuance of a permit or exemption and include:

withdrawal or non-participation in the Medicare and/or Medicaid programs;

charge information;

requirements of variances pursuant to Section 1125.560;

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other representations made to HFSRB as stipulated or agreed upon in the public record and specified in the application or the permit or exemption approval letter.

"Substantive Projects" means types of projects that are defined in the Act and classified as substantive. *Substantive projects shall include no more than the following:*

*Projects to construct a new or replacement facility located on a new site or a replacement facility located on the same site as the original facility and the costs of the replacement facility exceed the capital expenditure minimum.*

*Projects proposing a new service or discontinuation of a service, which shall be reviewed by the Board within 60 days.*

*Projects proposing a change in the bed capacity of an LTC facility by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation of beds from one facility to another by more than 20 beds or more than 10% of total bed capacity, as defined by the State Board, whichever is less, over a 2 year period. [20 ILCS 3960/12]*

"Technical Assistance" means help provided by an employee of HFSRB to a person, LTC facility or HFSRB, and is not considered ex parte communication as defined in Section 4.2 of the Act. Technical assistance may be provided to any person regarding pre-application conferences, the filing of an application, or other request to HFSRB provided that the communication is *not intended to influence any decision on the application*. Technical assistance may be provided for the benefit of HFSRB to clarify issues relevant to an application or other business of HFSRB. The assistance may be in the form of written correspondences, conversations, site visits, meetings, and/or consultations with independent experts. *Once an application or exemption is filed and deemed complete, a written record of any communication between staff and an applicant shall be prepared by staff and made part of the public record, using a prescribed, standardized format, and shall be included in the application file, within 10 business days after the assistance is provided. [20 ILCS 3960/4.2]*

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"Temporary Suspension of Facility or Category of Service" means a facility has ceased operation or has ceased to provide a category of service due to unanticipated or unforeseen circumstances (such as the loss of appropriate staff or a natural or unnatural disaster). A facility shall file notice to HFSRB of a temporary suspension of service. See 77 Ill. Adm. Code 1130.240(d).

**Section 1125.150 HFSRB Procedural Rules**

The Certificate of Need review process and all applicable procedures and requirements are contained in 77 Ill. Adm. Code 1130.

## SUBPART B: PLANNING POLICIES

**Section 1125.210 General Long-Term Nursing Care Category of Service**

- a) Planning Areas  
The 95 general long-term nursing care planning areas are located within the 11 Health Services Areas (HSAs).
- 1) HSA 1: Planning areas are Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago Counties.
  - 2) HSA 2: Planning areas are Bureau/Putnam, Henderson/Warren, Marshall/Stark, Fulton, Knox, LaSalle, McDonough, Peoria, Tazewell and Woodford Counties.
  - 3) HSA 3: Planning areas are Brown/Schuyler, Calhoun/Pike, Morgan/Scott, Adams, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery and Sangamon Counties.
  - 4) HSA 4: Planning areas are Coles/Cumberland, Champaign, Clark, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, McLean, Macon, Moultrie, Piatt, Shelby and Vermilion Counties.
  - 5) HSA 5: Planning areas are Alexander/Pulaski, Edwards/Wabash, Gallatin/Hamilton/Saline, Johnson/Massac, Hardin/Pope, Bond, Clay, Crawford, Effingham, Fayette, Franklin, Jackson, Jasper, Jefferson, Lawrence, Marion, Perry, Randolph, Richland, Union, Washington, Wayne, White and Williamson Counties.

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- 6) HSA 6: Planning Areas
  - A) 6A: City of Chicago Community Areas Rogers Park, West Ridge, Uptown, Lincoln Square, Edgewater, Edison Park, Norwood Park, Jefferson Park, Forest Glen, North Park, Albany Park, Portage Park, Irving Park and Avondale.
  - B) 6B: City of Chicago Community Areas North Center, Lakeview, Lincoln Park, Near North Side, Loop, Logan Square, West Town, Near West Side, Lower West Side, West Garfield Park, East Garfield Park, North Lawndale, South Lawndale, O'Hare, Dunning, Montclare, Belmont Cragin, Hermosa, Humboldt Park and Austin.
  - C) 6C: City of Chicago Community Areas Near North Side, Armour Square, Douglas, Oakland, Fuller Park, Grand Boulevard, Kenwood, Washington Park, Hyde Park, Woodlawn, South Shore, Chatham, Avalon Park, South Chicago, Burnside, Calumet Heights, Roseland, Pullman, South Deering, East Side, West Pullman, Riverdale, Hegewisch, Garfield Ridge, Archer Heights, Brighton Park, McKinley Park, Bridgeport, New City, West Elson, Gage Park, Clearing, West Lawn, Chicago Lawn, West Englewood, Englewood, Greater Grand Crossing, Ashburn, Auburn Gresham, Beverly, Washington Heights, Mount Greenwood and Morgan Park.
- 7) HSA 7: Planning Areas
  - A) 7A: Cook County Townships of Barrington, Palatine, Wheeling, Hanover, Schaumburg and Elk Grove.
  - B) 7B: Cook County Townships of Northfield, New Trier, Evanston, Niles and Maine.
  - C) 7C: DuPage County.
  - D) 7D: Cook County Townships of Norwood Park, Leyden, Proviso, River Forest, Oak Park, Riverside, Berwyn and Cicero.

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- E) 7E: Cook County Townships of Lyons, Lemont, Palos, Orland, Stickney, Worth, Calumet, Bremen, Thornton, Rich and Bloom.
  - 8) HSA 8: Planning areas are Kane, Lake and McHenry Counties.
  - 9) HSA 9: Planning areas are Grundy, Kankakee, Kendall and Will Counties.
  - 10) HSA 10: Planning areas are Henry, Mercer and Rock Island Counties.
  - 11) HSA 11: Planning areas are Clinton, Madison, Monroe and St. Clair Counties.
- b) Age Groups  
For general long-term nursing care, age groups of 0-64, 65-74, and 75 and over.
  - c) Utilization Target  
Facilities providing a general long-term nursing care service should operate those beds at a minimum annual average occupancy of 90% or higher.
  - d) Bed Capacity  
General long-term nursing care bed capacity is the licensed capacity for facilities subject to the Nursing Home Care Act and the total number of LTC beds for a facility as determined in the HFSRB Inventory for facilities not subject to the Nursing Home Care Act.
  - e) Need Determination  
The following methodology is utilized to determine the projected number of nursing care beds needed in a planning area:
    - 1) Establish minimum and maximum planning area use rates for the 0-64, the 65-74, and the 75 and over age groups as follows:
      - A) Divide the HSA's base year experienced nursing care patient days for each age group by the base year population estimate for each age group to determine the HSA experienced use rate for each age group;

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- B) the minimum planning area use rate for each age group is 60% of the HSA experienced use rate for each age group, and the maximum planning area use rate for each age group is 160% of the HSA experienced use rate for each age group;
- 2) Divide the planning area's base year experienced nursing care patient days for each age group by the base year population estimate for each group to determine the planning area experienced use rate for each age group;
  - 3) Determine the planning area's population projection, which is 10 years from the base year; the use rate for each age group is as follows:
    - A) If the experienced use rate for an age group is below the minimum use rate, the minimum use rate is the projected use rate for that age group;
    - B) If the experienced use rate for an age group is above the maximum use rate, the maximum use rate is the projected use rate for that age group;
    - C) If the experienced use rate for an age group is above the minimum use rate and below the maximum use rate, the experienced use rate for the age group is the projected use rate for that age group;
  - 4) Multiply each age group's projected use rate times the projected population for the age group to determine the projected patient days for each age group;
  - 5) Total the projected patient days for the age groups to determine the planning area's total projected patient days;
  - 6) Divide the planning area's total projected patient days by the number of days in the projected year to obtain the projected average daily census;
  - 7) Divide the projected average daily census by .90 (90% occupancy factor) to obtain the projected planning area bed need;
  - 8) Subtract the number of existing beds in the planning area from the projected planning area bed need to determine the projected number of

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excess (surplus) beds or the projected need for additional (deficit) beds in an area.

**Section 1125.220 Specialized Long-Term Care Categories of Service**

- a) Categories of Service:
  - 1) Chronic Mental Illness (MI);
  - 2) Long-Term Care for the Developmentally Disabled (Adult) (DD-Adult); and
  - 3) Long-Term Care for the Developmentally Disabled (Children) (DD-Children).
- b) Planning Areas:
  - 1) The State of Illinois is utilized for the MI category of service.
  - 2) Health Service Areas are utilized for the DD-Children category of service.
  - 3) For DD-Adult category of service:

HSA I, HSA II, HSA III, HSA IV, HSA V, HSA X, HSA XI, and the combined HSAs VI, VII, VIII and IX.
- c) Occupancy Targets:
  - 1) Modernization 80%; Additional Beds 90% for the MI category of service; and
  - 2) Modernization 80%; Additional Beds 93% for the DD-Adult and DD-Children categories of service.
- d) Bed Capacity: For facilities licensed pursuant to the Nursing Home Care Act, the bed capacity is the licensed bed capacity for the service.
- e) Bed Need Determination for the Specialized Categories of Service:

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- 1) No formula bed need for the MI and DD-Children categories of service has been developed. It is the responsibility of the applicant to document the need for the service by complying with all applicable review criteria contained in 77 Ill. Adm. Code 1110.Subpart S.
- 2) Bed need for the DD-Adult category of service is calculated in two parts:
  - A) For facilities licensed as ICF/DD 16-bed or fewer, total bed need and the number of additional beds needed are determined by dividing the planning area's projected adult developmentally disabled population by 21.4 to determine the total number of beds needed for developmentally disabled adult residents in the planning area. The number of additional beds needed or excess beds is determined by subtracting the number of existing beds in ICF/DD 16-bed or fewer facilities from the total number of beds needed for developmentally disabled adult residents in the planning area.
  - B) For facilities with more than 16 beds, no bed need formula has been established.

## SUBPART C: GENERAL INFORMATION REQUIREMENTS

**Section 1125.310 Introduction**

The information requirements contained in this Subpart are applicable to all projects. An applicant shall document the *qualifications, background, character and financial resources to adequately provide a proper service for the community* and also demonstrate that the project promotes the *orderly and economic development of LTC facilities in the State of Illinois that avoids unnecessary duplication of facilities or service*. [20 ILCS 3960/2]

**Section 1125.320 Purpose of the Project – Information Requirements**

The applicant shall document that the project will provide health services that improve the long-term nursing care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other, per the applicant's definition.

- a) The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be

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provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of this information include:

- 1) The area's demographics or characteristics (e.g., rapid area growth rate, increased aging population) that may affect the need for services in the future;
- 2) The population's morbidity or mortality rates;
- 3) The incidence of various diseases in the area;
  - A) The population's financial ability to access LTC (e.g., financial hardship, increased number of charity care patients/residents, changes in the area population's insurance or managed care status);
  - B) The physical accessibility to necessary LTC (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).
- b) The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).
- c) The applicant shall detail how the project will address or improve the issues listed in subsection (a), as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific time frames that relate to achieving the stated goals.
- d) For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.

**Section 1125.330 Alternatives to the Proposed Project – Information Requirements**

The applicant shall document that the proposed project is the most effective or least costly alternative for meeting the LTC needs of the population to be served by the project.

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- a) Alternative options shall be addressed. Examples of alternative options include:
- 1) Proposing a project of greater or lesser scope and cost;
  - 2) Pursuing a joint venture or similar arrangement with one or more providers;
  - 3) Developing alternative settings to meet all or a portion of the project's intended purposes; and
  - 4) Utilizing other LTC resources that are available to serve all or a portion of the population proposed to be served by the project.
- b) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, resident/patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.
- c) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available.

## SUBPART D: GENERAL LONG-TERM CARE – REVIEW CRITERIA

**Section 1125.510 Introduction**

- a) This Subpart applies to projects involving General Long-Term Care. Applicants proposing to establish, expand or modernize the General Long-Term Care category of service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
	Section	Subject
<b>Establishment of Services or Facility</b>	.520	Background of the Applicant
	.530(a)	Bed Need Determination
	.530(b)	Service to Planning Area Residents
	.540(a) or (b) + (c)	Service Demand –

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	+ (d) or (e)	Establishment of General Long Term Care
	.570(a) & (b)	Service Accessibility
	.580(a) & (b)	Unnecessary Duplication & Maldistribution
	.580(c)	Impact of Project on Other Area Providers
	.590	Staffing Availability
	.600	Bed Capacity
	.610	Community Related Functions
	.620	Project Size
	.630	Zoning
	.640	Assurances
<b>Expansion of Existing Services</b>	.520	Background of the Applicant
	.530(b)	Service to Planning Area Residents
	.550(a) + (b) or (c)	Service Demand – Expansion of General Long-Term Care
	.590	Staffing Availability
	.600	Bed Capacity
	.620	Project Size
<b>Continuum of Care – Establishment or Expansion</b>	.520	Background of the Applicant
	.560(a)(1) & (3)	Continuum of Care Components
	.590	Staffing Availability
	.600	Bed Capacity
	.610	Community Related Functions
	.630	Zoning
<b>Defined Population – Establishment or Expansion</b>	.520	Background of the Applicant
	.560(b)(1) & (2)	Defined Population to be Served
	.590	Staffing Availability
	.600	Bed Capacity

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	.610	Community Related Functions
	.630	Zoning
	.640	Assurances

<b>Modernization</b>	.650(a)	Deteriorated Facilities
	.650(b) & (c)	Documentation
	.650(d)	Utilization
	.600	Bed Capacity
	.610	Community Related Functions
	.620	Project Size
	.630	Zoning

- b) If the proposed project involves the replacement of a facility or service onsite, the applicant shall comply with the requirements listed in Section 1125.650 (Modernization) plus Section 1125.640.
- c) If the proposed project involves the replacement of a facility or service on a new site, the applicant shall comply with the requirements listed in the chart in subsection (a) under Establishment of Services or Facility.
- d) If the proposed project involves the replacement of a facility or service (onsite or new site), the number of beds being replaced shall not exceed the number justified by historical occupancy rates for each of the latest two years, unless additional beds can be justified per the criteria for Expansion of Existing Services in the chart in subsection (a).
- e) All applicants shall address the requirements listed in Section 1125.520 (Background of the Applicant).

**Section 1125.520 Background of the Applicant – Review Criterion**

All applicants shall comply with the requirements of this Section, as follows:

- a) An applicant must demonstrate that it is fit, willing and able, and *has the qualifications, background and character, to adequately provide a proper standard of LTC service for the community.* [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFSRB shall consider whether adverse action has been taken against the applicant, or against any LTC facility owned or operated by the applicant, directly or indirectly, within three

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years preceding the filing of the application. An LTC facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by that person or entity. (See Section 1125.140 for the definition of "adverse action".)

- b) Examples of Facilities Owned or Operated by an Applicant
- 1) The applicant, Partnership ABC, owns 60% of the shares of Corporation XYZ that manages the Good Care Nursing Home under a management agreement. The applicant, Partnership ABC, owns or operates Good Care Nursing Home.
  - 2) The applicant, Healthy LTC, a corporation, is a subsidiary of Universal Health, the parent corporation of Healthcenter Services, its wholly-owned subsidiary. The applicant, Healthy LTC, owns and operates Healthcenter Services.
  - 3) Dr. Wellcare is the applicant. His wife is the director of a corporation that owns an LTC. The applicant, Dr. Wellcare, owns or operates the LTC.
  - 4) Drs. Faith, Hope and Charity own 40%, 35% and 10%, respectively, of the shares of Healthfair, Inc., a corporation, which is the applicant. Dr. Charity owns 45% and Drs. Well and Care each own 25% of the shares of XYZ Nursing Home, Inc. The applicant, Healthfair, Inc., owns and operates XYZ Nursing Home, Inc.
- c) The applicant shall submit the following information:
- 1) A listing of all LTC facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, as applicable;
  - 2) A certified listing from the applicant of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application; and
  - 3) Authorization permitting HFSRB and IDPH access to any documents necessary to verify the information submitted, including, but not limited

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to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide the authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.

- d) If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this Section. In these instances, the applicant shall attest that the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed to update and/or clarify data.

**Section 1125.530 Planning Area Need – Review Criterion**

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

- a) Bed Need Determination
- 1) The number of beds to be established for general LTC is in conformance with the projected bed need specified and reflected in the latest updates to the HFSRB Inventory.
  - 2) The number of beds proposed shall meet or exceed the occupancy standard specified in Section 1125.210(c).
- b) Service to Planning Area Residents
- 1) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary LTC to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.
  - 2) Applicants proposing to add beds to an existing general LTC service shall provide resident/patient origin information for all admissions for the last

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12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected resident volume will be from residents of the area.

- 3) Applicants proposing to expand an existing general LTC service shall submit resident/patient origin information by zip code, based upon the resident's/patient's legal residence (other than an LTC facility).

**Section 1125.540 Service Demand – Establishment of General Long-Term Care**

- a) The number of beds proposed to establish a new general long-term care service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or if the applicant proposes to establish a new LTC facility, the applicant shall submit projected referrals. The applicant shall document subsection (c) and subsection (d) or (e).
- b) If the applicant is not an existing facility and proposes to establish a new general LTC facility, the applicant shall submit the number of annual projected referrals, as required in subsection (d) or (e).
- c) **Historical Referrals**  
If the applicant is an existing facility and is proposing to establish this category of service, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.  
Documentation of the referrals shall include: resident/patient origin by zip code; name and specialty of referring physician or identification of another referral source; and name and location of the recipient LTC facility.
- d) **Projected Referrals**  
An applicant proposing to establish a category of service or establish a new LTC facility shall submit the following:
  - 1) Letters from referral sources (hospitals, physicians, social services and others) that attest to total number of prospective residents (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application. Referral sources shall verify their projections and the methodology used;

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- 2) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources' documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;
  - 3) Each referral letter shall contain the referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and
  - 4) Verification by the referral sources that the prospective resident referrals have not been used to support another pending or approved Certificate of Need (CON) application for the subject services.
- e) Projected Service Demand – Based on Rapid Population Growth
- If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as follows:
- 1) The applicant shall define the facility's market area based upon historical resident/patient origin data by zip code or census tract;
  - 2) Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Bureau of the Census or IDPH;
  - 3) Projections shall be for a maximum period of 10 years from the date the application is submitted;
  - 4) Historical data used to calculate projections shall be for a number of years no less than the number of years projected;
  - 5) Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to or in excess of the projection horizon;

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- 6) Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application (see the HFSRB Inventory); and
- 7) Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB.

**Section 1125.550 Service Demand – Expansion of General Long-Term Care**

The number of beds to be added at an existing facility is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (a) and either subsection (b) or (c).

- a) Historical Service Demand
  - 1) An average annual occupancy rate that has equaled or exceeded occupancy standards for general LTC, as specified in Section 1125.210(c), for each of the latest two years.
  - 2) If prospective residents have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including completed applications that could not be accepted due to lack of the subject service and documentation from referral sources, with identification of those patients by initials and date.
- b) Projected Referrals  
The applicant shall provide documentation as described in Section 1125.540(d).
- c) Projected Service Demand – Based on Rapid Population Growth  
If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand shall be determined as described in Section 1125.540 (e).

**Section 1125.560 Variances to Computed Bed Need**

- a) Continuum of Care  
The applicant proposing a continuum of care project shall demonstrate the following:

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- 1) The project will provide a continuum of care for a geriatric population that includes independent living and/or congregate housing (such as unlicensed apartments, high rises for the elderly and retirement villages) and related health and social services. The housing complex shall be on the same site as the health facility component of the project.
  - 2) The proposal shall be for the purposes of and serve only the residents of the housing complex and shall be developed either after the housing complex has been established or as a part of a total housing construction program, provided that the entire complex is one inseparable project, that there is a documented demand for the housing, and that the licensed beds will not be built first, but will be built concurrently with or after the residential units.
  - 3) The applicant shall demonstrate that:
    - A) The proposed number of beds is needed. Documentation shall consist of a list of available patients/residents needing the proposed project. The proposed number of beds shall not exceed one licensed LTC bed for every five apartments or independent living units;
    - B) There is a provision in the facility's written operational policies assuring that a resident of the retirement community who is transferred to the LTC facility will not lose his/her apartment unit or be transferred to another LTC facility solely because of the resident's altered financial status or medical indigency; and
    - C) That admissions to the LTC unit will be limited to current residents of the independent living units and/or congregate housing.
- b) **Defined Population**  
The applicant proposing a project for a defined population shall provide the following:
- 1) The applicant shall document that the proposed project will serve a defined population group of a religious, fraternal or ethnic nature from throughout the entire health service area or from a larger geographic

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service area (GSA) proposed to be served and that includes, at a minimum, the entire health service area in which the facility is or will be physically located.

- 2) The applicant shall document each of the following:
  - A) A description of the proposed religious, fraternal or ethnic group proposed to be served;
  - B) The boundaries of the GSA;
  - C) The number of individuals in the defined population who live within the proposed GSA, including the source of the figures;
  - D) That the proposed services do not exist in the GSA where the facility is or will be located;
  - E) That the services cannot be instituted at existing facilities within the GSA in sufficient numbers to accommodate the group's needs. The applicant shall specify each proposed service that is not available in the GSA's existing facilities and the basis for determining why that service could not be provided.
  - F) That at least 85% of the residents of the facility will be members of the defined population group. Documentation shall consist of a written admission policy insuring that the requirements of this subsection (b)(2)(F) will be met.
  - G) That the proposed project is either directly owned or sponsored by, or affiliated with, the religious, fraternal or ethnic group that has been defined as the population to be served by the project. The applicant shall provide legally binding documents that prove ownership, sponsorship or affiliation.

**Section 1125.570 Service Accessibility**

The number of beds being established or added for each category of service is necessary to improve access for planning area residents.

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- a) **Service Restrictions**  
The applicant shall document that at least one of the following factors exists in the planning area, as applicable:
- 1) The absence of the proposed service within the planning area;
  - 2) Access limitations due to payor status of patients/residents, including, but not limited to, individuals with LTC coverage through Medicare, Medicaid, managed care or charity care;
  - 3) Restrictive admission policies of existing providers;
  - 4) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;
  - 5) For purposes of this Section 1125.570 only, all services within the 45-minute normal travel time meet or exceed the occupancy standard specified in Section 1125.210(c).
- b) **Supporting Documentation**  
The applicant shall provide the following documentation, as applicable, concerning existing restrictions to service access:
- 1) The location and utilization of other planning area service providers;
  - 2) Patient/resident location information by zip code;
  - 3) Independent time-travel studies;
  - 4) Certification of a waiting list;
  - 5) Admission restrictions that exist in area providers;
  - 6) An assessment of area population characteristics that document that access problems exist;

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- 7) Most recently published IDPH Long Term Care Facilities Inventory and Data (see [www.hfsrb.illinois.gov](http://www.hfsrb.illinois.gov)).

**Section 1125.580 Unnecessary Duplication/Maldistribution**

- a) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:
  - 1) A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;
  - 2) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and
  - 3) The names and locations of all existing or approved LTC facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.
- b) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as, but not limited to:
  - 1) A ratio of beds to population that exceeds one and one-half times the State average;
  - 2) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to Section 1125.210(c); or
  - 3) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards.
- c) The applicant shall document that, within 24 months after project completion, the proposed project:
  - 1) Will not lower the utilization of other area providers below the occupancy standards specified in Section 1125.210(c); and

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- 2) Will not lower, to a further extent, the utilization of other area facilities that are currently (during the latest 12-month period) operating below the occupancy standards.

**Section 1125.590 Staffing Availability**

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that staffing requirements of licensure, certification and applicable accrediting agencies can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

**Section 1125.600 Bed Capacity**

The maximum bed capacity of a general LTC facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient/resident care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c (Long-Term Care Facilities)) over a two-year period.

**Section 1125.610 Community Related Functions**

The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from those organizations.

**Section 1125.620 Project Size – Review Criterion**

The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix A, unless the additional GSF can be justified by documenting one of the following:

- a) Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

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- b) The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix A;
- c) The project involves the conversion of existing bed space that results in excess square footage.

**Section 1125.630 Zoning**

The applicant shall document one of the following:

- a) The property to be utilized has been zoned for the type of facility to be developed;
- b) Zoning approval has been received; or
- c) A variance in zoning for the project is to be sought.

**Section 1125.640 Assurances**

- a) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in Section 1125.210(c) for each category of service involved in the proposal.
- b) For beds that have been approved based upon representations for continuum of care (Section 1125.560(a)) or defined population (Section 1125.560(b)), the facility shall provide assurance that it will maintain admissions limitations as specified in those Sections for the life of the facility. To eliminate or modify the admissions limitations, prior approval of HFSRB will be required.

**Section 1125.650 Modernization**

- a) If the project involves modernization of a category of LTC bed service, the applicant shall document that the bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:
  - 1) High cost of maintenance;

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- 2) Non-compliance with licensing or life safety codes;
  - 3) Changes in standards of care (e.g., private versus multiple bed rooms); or
  - 4) Additional space for diagnostic or therapeutic purposes.
- b) Documentation shall include the most recent:
- 1) IDPH and CMMS inspection reports; and
  - 2) Accrediting agency reports.
- c) Other documentation shall include the following, as applicable to the factors cited in the application:
- 1) Copies of maintenance reports;
  - 2) Copies of citations for life safety code violations; and
  - 3) Other pertinent reports and data.
- d) Projects involving the replacement or modernization of a category of service or facility shall meet or exceed the occupancy standards for the categories of service, as specified in Section 1125.210(c).

SUBPART E: SPECIALIZED LONG-TERM CARE – [REVIEW CRITERIA](#)**Section 1125.710 Introduction**

Section 1125.720 contains review criteria that pertain to the Specialized Long-Term Care Category of Service. These review criteria are utilized in addition to the General Information Requirements outlined in Subpart C and any other applicable review criteria outlined in Subpart F. These review criteria shall apply to all specialized LTC projects in the review process, at the time they become effective, and to all subsequent applications relating to specialized LTC.

**Section 1125.720 Specialized Long-Term Care – Review Criteria**

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- a) Facility Size – Review Criterion. The maximum unit size is 100 beds, unless the project is for a State-operated facility or for the long-term medical care for children category of service.
- b) Community Related Functions – Review Criterion. The applicant shall document the written endorsement of community groups and shall include the following:
  - 1) a detailed description of the steps taken to inform and receive input from the public, including those community members who live in close proximity to the proposed facility's location;
  - 2) endorsements from social service, social and economic organizations; and
  - 3) support from municipal officials and other elected officials representing the area in which the proposed facility is located.
- c) Availability of Ancillary and Support Programs – Review Criterion. An applicant proposing the establishment of an ICF/DD facility of 16 beds or fewer must document that the community has the necessary support services available to provide care to the proposed facility's residents. The documentation must include:
  - 1) a copy of the letter, sent by certified mail, return receipt requested, to each of the day programs in the area informing them of the proposed project and requesting their comments regarding the impact of the proposed project on their programs. The applicant shall also provide copies of the responses received to these letters;
  - 2) a description of the transportation services available to the proposed residents;
  - 3) a description of the specialized services, other than day programs, available to the proposed residents;
  - 4) a description of the availability of community activities for the proposed facility's residents, e.g., movie theaters, bowling alleys, etc.; and
  - 5) documentation of the availability of a community workshop to serve the residents.

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- d) Recommendations from State Departments – Review Criterion. An applicant proposing a facility for the developmentally disabled must document contact with the Department of Human Services and the Department of Healthcare and Family Services. Documentation must include proof that a request has been submitted to each Department requesting that they determine the project's consistency with the long-range goals and objectives of those Departments and requesting the identification of individuals in need of the service. The Departments' responses should address, on both a statewide and a planning area basis, whether the proposed project meets the Department's planning objectives regarding the size, type and number of beds proposed, whether the project conforms or does not conform to each Department's plan, and how the project assists or hinders each Department in achieving its planning objectives. Such a request must be made by certified mail, return receipt requested, and must occur within a 60-day period prior to the submission of the application.
- e) Long-Term Medical Care for Children Category of Service (Only) – Review Criterion. The applicant must document the following:
- 1) the planning area served by the facility and the size of the specialized population (age 0-18 years) to be served within that geographic area. Documentation must include, but is not limited to, any reports or studies showing the points of origin of patients/residents admitted to the facility, preferably for the latest 12-month period for which data is available;
  - 2) identification of the special programs and/or services to be provided or currently offered by the applicant and the relationship of the programs to the needs of the specialized population;
  - 3) insufficient service capability currently exists to meet this need; and
  - 4) the number of beds in the proposed project is needed. Provide documentation that the proposed project will achieve, within the first year of operation, an occupancy of at least 90%.
- f) Zoning – Review Criterion. The applicant must document that:
- 1) the property to be utilized has been zoned for the type of facility to be developed; or

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- 2) zoning approval has been received; or
  - 3) a certificate of need is required by the local zoning authority before zoning can be approved. This documentation shall include a letter from the appropriate zoning official indicating that such a requirement exists.
- g) Establishment of Chronic Mental Illness – Review Criterion. Documentation shall consist of a narrative statement detailing the scope of system changes that have brought about the need for the project and historical utilization of facilities involved. The applicant must document that:
- 1) all beds will be operated by the State of Illinois;
  - 2) the resident population and type of resident/patient served has changed, necessitating the establishment or expansion of services in order to meet the needs of the facility's residents;
  - 3) the project represents redistribution of existing beds from another facility due to closure of the facility or unit; and
  - 4) admissions from the general public have increased over the last two-year period and the expansion is necessary in order to adequately serve the residents of the facility and the general public.
- h) Establishment of Beds, Developmentally Disabled-Adult Category of Service – Review Criterion. Any proposed project to establish a facility of 16 beds or fewer must be located in a planning area where a need for additional beds is calculated as shown in Section 1125.220(e), unless the applicant can document compliance with the requirements for a variance to the computed bed need in subsection (i) of this Section.
- i) Variance to Computed Bed Need for Establishment of Beds, Developmentally Disabled-Adult Category of Service, for Placement of Residents from Department of Human Services (DHS) Operated Beds – Review Criterion. The applicant must document all of the following:
- 1) That each of the residents proposed to be served:

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- A) currently resides in a DHS-operated facility and has at least one interested family member residing in the proposed planning area or has an interested family member who resides out-of-state within 15 miles of the proposed planning area boundary; or
  - B) has resided in a DHS-operated facility physically located in the proposed project's planning area for at least the last 2 years, and the consent of the resident's legal guardian has been obtained for the relocation.
- 2) All of the existing 16-bed or fewer facilities in the planning area are occupied at or above the 93% target occupancy rate or those facilities have refused to accept residents referred from DHS-operated facilities. Documentation of each refusal must include the following:
- A) a letter from DHS stating the number of times in the last 12 months the facility or facilities have refused to accept referrals of DHS-operated facility residents, including the name of the facility, the date of the refusal, and the reasons cited for the refusals, if any;
  - B) a copy of the letter, sent by certified mail, return receipt requested, to each of the underutilized facilities in the area asking if they accept referrals from DHS-operated facilities, listing the dates of each past refusal, and requesting an explanation of the basis for the refusal in each instance;
  - C) copies of the responses to the letters required by subsections (i)(2)(a) and (b); and
  - D) a letter from DHS indicating that each of the residents to be referred to the proposed facility has been refused admission at all of the other 16-bed or fewer facilities in the planning area.
- 3) That the proposed relocation of a resident will result in cost savings to the State.
- 4) That the facility will only accept future referrals from the DHS-operated facility in the planning area if a bed is available.

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- 5) An explanation of how the proposed facility conforms with or deviates from the DHS comprehensive long range development plan for developmental disabilities services.
- j) State Board Consideration of Public Hearing Testimony – Review Criterion. If public hearing testimony is presented that indicates that one or more facilities in the planning area have available beds, and are willing to accept DHS referrals, HFSRB shall notify DHS and request that DHS contact the facility or facilities and attempt to place residents in the available beds, thereby reducing the need for the proposed additional beds. DHS shall notify HFSRB of the results of these placement efforts within 45 days after the date of HFSRB advice. If DHS' response is not received by HFSRB within the specified time period, HFSRB shall assume that the patients/residents were placed appropriately and that the need for the additional beds no longer exists. If the existing facility or facilities refuses to accept the referrals, HFSRB shall be notified by DHS of the refusal and of any rationale for the refusal provided to DHS by the refusing facility. This material shall then be forwarded to the Board for its consideration. The review period set forth in 77 Ill. Adm. Code 1130.610(b) may be extended by HFSRB for a period not to exceed 60 days.

## SUBPART F: FINANCIAL AND ECONOMIC FEASIBILITY – REVIEW CRITERIA

**Section 1125.800 Estimated Total Project Cost**

- a) All applicants shall address the requirements listed in this Section, as applicable. The applicant shall provide project cost information for each of the following components as is applicable. When a project or any component of a project is to be accomplished by lease, donation, gift or any other means, the fair market value or dollar value that would have been required for purchase, construction or acquisition shall be included in the estimated total project cost.
  - 1) Preplanning costs – includes costs incurred prior to the submission of an application, such as development and feasibility studies, market studies, legal fees, bid solicitation, etc.;
  - 2) Site survey and soil investigation fees – includes costs for surrounding surveying of a proposed project site and resulting soil investigation fees;

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- 3) Site preparation – includes costs of rental equipment for earthwork, concrete, lifting and hoisting, site drainage, utilities, demolition of existing structures, clearing, grading and earthwork;
- 4) Off-site work – includes costs of drainage, pipes, utilities, sewage, roads and walks;
- 5) Construction and modernization contracts – includes expenses covered under the construction contract, including major medical and other fixed equipment, contractor's overhead and profit;
- 6) Contingencies – means an allowance for unforeseeable events relating to construction or modernization;
- 7) Architectural & engineering fees – includes fees associated with the development and implementation of drawings and design materials for a proposed project;
- 8) Consulting and other fees – includes charges for the services of various types of consulting and professional expertise, including environmental impact, acoustical studies, computer software fees, etc.;
- 9) Movable capital equipment not in construction contracts – includes the cost of all movable capital equipment, including any movable major medical equipment and the cost of installation of the equipment, excluding any trade-in allowances on existing equipment;
- 10) Bond issuance expense – includes all costs associated with the issuance of bonds to finance a project, including issuer's fees, bond counsel's fees, official statements (feasibility study), official statement printing, printing of bonds, survey of the collateral site, title insurance to property, auditor's fees, trustee fees, underwriters' discount and government fees (if applicable);
- 11) Net interest expense during construction – means the difference between interest earned on funds for construction and interest expense on the amount of borrowed funds;

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- 12) Other costs to be capitalized – includes miscellaneous fees and working capital expenses related to the project; and
  - 13) Acquisition of buildings or other property – includes the cost incurred (or the fair market value) for the acquisition of buildings or property for the project. Any acquisition that has occurred within two years from the date the application for permit is submitted must be included as part of project costs.
- b) Related Cost Data
- 1) Land Acquisition Cost – The applicant shall provide the purchase price or fair market value, whichever is applicable, for the acquisition of land that is required in order to undertake the project. Acquisition of land is not a capital expenditure and is not included as part of project costs.
  - 2) Operating Start-Up Cost – The applicant shall provide a schedule of estimated non-capitalized operating start-up costs and an estimate of any initial operating deficit.  
HFSRB NOTE: Any capitalized costs that are related to the start-up costs of a facility must be included in the total estimated project cost.
  - 3) Construction and Modernization Costs and Schedule – The applicant shall provide a construction or project completion schedule that details the anticipated dates and percent of project construction or modernization completion at the 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup>, 95<sup>th</sup> and 100<sup>th</sup> percentile of project funds expended.
  - 4) Debt Service Relief Fund – Applicants shall provide the amount that will be placed in a debt service reserve fund and shall also provide the terms and conditions of uses of the fund.
- c) Information Requirements for Financial Feasibility
- 1) The applicant shall provide (for the LTC facility or for the person who controls the LTC facility) either documentation of a U.S. Department of Housing and Urban Development (HUD) insured mortgage commitment, historical financial statements, or evidence of financial resources to fund the project.

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- 2) Historical Financial Statements – The applicant shall provide (for the LTC facility or for the person who controls the LTC facility) the most recent three years' financial statements (if available) that include the following:
  - A) Balance sheet;
  - B) Income statement;
  - C) Changes in fund balance; and
  - D) Change in financial position.
- 3) Projected Capital Costs – The applicant must provide the annual projected capital costs (depreciation, amortization and interest expense) for:
  - A) The first full fiscal year after project completion; or
  - B) The first full fiscal year when the project achieves or exceeds the average occupancy rate in the market area (or target occupancy), whichever is later.
- 4) Projected Operating Costs – The applicant shall provide projected operating costs (excluding depreciation and stated in current dollars based on the full-time equivalents (FTEs) and other resource requirements) for the first full fiscal year after project completion or the first full fiscal year when the project achieves or exceeds the average occupancy rate in the market area (or target occupancy), whichever is later, including:
  - A) Annual operating costs; and
  - B) Annual operating costs change (increase or decrease) attributable to the project.
- 5) Availability of Funds – The applicant shall document that financial resources will be available and be equal to or exceed the estimated total project cost and any related cost. An applicant that has no documented HUD insured mortgage commitment shall document that the project and related costs will be:

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- A) Funded in total with cash and equivalents, including investment securities, unrestricted funds, and funded depreciation as currently defined by the Medicare statute (42 USC 1395 et seq.); or
- B) Funded in total or in part by borrowing because:
  - i) a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
  - ii) Borrowing is less costly than the liquidation of existing investments.
- 6) Operating Start-up Costs – The applicant shall document that financial resources will be available and be equal to or exceed any start-up expenses and any initial operating deficit.
- 7) Financial Viability – The applicant shall demonstrate the financial feasibility of the project based upon the projection of reasonable Medicare, Medicaid and private pay charges, expenses of operation, and staffing patterns relative to other facilities in the market area in which the proposed project will be located.
- 8) Previous Certificate of Need Projects – The applicant shall describe its previous record of implementing certificate of need-approved LTC projects.
- 9) Financial and Economic Review Standard Ratios for New Facilities – The proposed project shall comply with the ratio standards cited in Appendix B. Applicants not in compliance with any of the viability ratios shall document the reasons for non-compliance.

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**Section 1125.APPENDIX A Project Size Standards – Square Footage and Utilization**

The following standards apply to new construction, the development of freestanding facilities, modernization, and the development of facilities in existing structures, including the use of leased space. For new construction, the standards are based on the inclusion of all building components and are expressed in building gross square feet (BGSF). For modernization projects, the standards are based upon interior build-out only and are expressed in departmental gross square feet (DGSF). Spaces to be included in the applicant's determination of square footage shall include all functional areas minimally required for the applicable service areas, by the appropriate rules, required for IDPH licensure and/or federal certification and any additional spaces required by the applicant's operational program.

Service Areas	Square Feet/Unit	Annual Utilization/Unit
General Long-Term Care	435-713 BGSF/Bed 350-570 DGSF/Bed	See Section 1125.210(c)

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**Section 1125.APPENDIX B Financial and Economic Review Standards**

## a) Reasonableness of Project and Related Costs Standards

- 1) **Preplanning**  
Costs shall not exceed 1.8% of construction and modernization contracts plus contingencies plus equipment costs.
- 2) **Site Survey and Preparation**  
Costs shall not exceed 5% of construction and contingency costs.
- 3) **New Construction and Modernization Costs per Gross Square Foot (GSF)**  
Hospital and long-term care (LTC) cost standards are derived from the RSMeans Building Construction Cost Data (Means) publication (RSMeans, 63 Smiths Lane, PO Box 800, Kingston MA 02364-9988, 800/334-3509; 2008, no later amendments or editions included) and will be adjusted (for inflation and location) for each project to the current year ([www.rsmeans.com](http://www.rsmeans.com)). Cost standards for the other types of facilities are derived from the third quartile costs of previously approved projects and are to be adjusted to the current year based upon historic inflation rates from RSMeans.

HFSRB NOTE: HFSRB staff will review the cost per square foot data submitted in the application to determine compliance with the latest available cost standards of the RSMeans publication.

HFSRB NOTE: Modernization includes the build out of leased space and shall include the cost of all capital improvements contained in the terms of the lease. These standards are based on 2008 data.

<b>Type of Facility</b>	<b>New Construction</b>	<b>Modernization</b>
LTC (includes ICF/DD facilities)	Adjusted Means 3 <sup>rd</sup> Quartile	70% of Adjusted Means 3 <sup>rd</sup> Quartile

- 4) **Contingencies**  
Contingency costs for projects (or for components of projects) are based upon a percentage of new construction or modernization costs and are based upon the status of a project's architectural contract documents.

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<b>Status of Project</b>	<b>New Construction</b>	<b>Modernization</b>
Contract Documents	Components	Components
Schematics	10%	10-15%
Preliminary	7%	7-10%
Final	3-5%	5-7%

5) New Construction or Modernization Fees and Architectural & Engineering (A&E) Fees

Current fees for services for projects or components of projects involving new construction or modernization (total amount of construction and contingencies, A&E fees for LTC facilities and total fees for site work) can be found in the Centralized Fee Negotiation Professional Services and Fees Handbook (available at [www.cdb.state.il.us](http://www.cdb.state.il.us) or by contacting the Capital Development Board, 401 South Spring Street, Springfield, Illinois 62706). HFSRB shall, for all calculations, consider the latest version of the handbook as released on the Capital Development Board website.

A) Projects or Components of Projects Involving New Construction

<b>Total Amount of Construction and Contingencies</b>	<b>LTC Facilities</b>
under \$100,000	10.59-15.89%
\$ 200,000	9.99-14.99%
\$ 300,000	9.48-14.22%
\$ 400,000	9.03-13.55%
\$ 500,000	8.65-12.99%
\$ 700,000	8.21-12.33%
\$ 900,000	7.89-11.85%
\$ 1,000,000	7.79-11.69%
\$ 1,250,000	7.62-11.44%
\$ 1,500,000	7.49-11.25%
\$ 1,750,000	7.36-11.06%
\$ 2,500,000	7.06-10.60%
\$ 3,000,000	6.89-10.35%
\$ 5,000,000	6.42-9.64%
\$ 7,000,000	6.11-9.17%

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\$ 9,000,000	5.94-8.92%
\$ 10,000,000	5.90-8.86%
\$ 15,000,000	5.76-8.66%
\$ 20,000,000	5.64-8.48%
\$ 25,000,000	5.52-8.28%
\$ 30,000,000	5.37-8.07%
\$ 40,000,000	5.12-7.68%
\$ 50,000,000	4.86-7.30%
\$100,000,000 and over	3.59-5.39%

## B) Projects or Components of Projects Involving Modernization

<b>Total Amount of Construction and Contingencies</b>	<b>A&amp;E Fees for LTC facilities</b>
under \$100,000	10.76-16.16%
\$ 200,000	10.16-15.26%
\$ 300,000	9.65-14.49%
\$ 400,000	9.20-13.80%
\$ 500,000	8.81-13.23%
\$ 700,000	8.36-12.56%
\$ 900,000	8.04-12.06%
\$ 1,000,000	7.93-11.91%
\$ 1,250,000	7.76-11.66%
\$ 1,500,000	7.63-11.45%
\$ 1,750,000	7.50-11.26%
\$ 2,000,000	7.40-11.12%
\$ 2,500,000	7.19-10.79%
\$ 3,000,000	7.02-10.54%
\$ 5,000,000	6.54-9.82%
\$ 7,000,000	6.22-9.34%
\$ 9,000,000	6.04-9.08%
\$ 10,000,000	6.00-9.02%
\$ 15,000,000	5.87-8.81%
\$ 20,000,000	5.74-8.62%
\$ 25,000,000	5.62-8.44%
\$ 30,000,000	5.48-8.22%

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\$ 40,000,000	5.21-7.83%
\$ 50,000,000	4.95-7.43%
\$100,000,000 and over	3.65-5.49%

- 6) **Capital Equipment Not Included in Construction Contracts**  
Standards for capital equipment not included in construction contracts are established by type of facility and are derived from the third quartile costs of previously approved projects for which data are available. The standards apply only to the following types of projects: establishment of new facilities, expansion of existing facilities (e.g., bed additions, station additions, or operating/treatment room additions), and modernization of existing facilities involving replacement of existing beds, relocation of existing facilities, replacement of ASTC operating or procedure room equipment, etc. The standards below are calculated for the year 2008. These will be inflated to the current year using the inflation of major medical equipment by the department. (Long-Term Care standard includes ICF/DD.)

HFSRB NOTE: Modernization includes the build out of leased space and shall include the cost of capital equipment included in the terms of the lease.

**LTCs per Bed**

\$6,491

- 7) **Inflation Factor**  
Costs for construction and modernization contracts and equipment are to be adjusted for projected inflation. The projected inflation rate is to be calculated to the midpoint of construction. For construction midpoint of up to 3 years, the inflation rate shall be an average of the previous 3 years annual inflation rates for construction as determined by RSMMeans. For construction midpoints beyond 3 years, the inflation rate shall be the lesser of this rate or 3% for the period of time beyond 3 years.
- b) **Financial Viability Standards**
- 1) **Current Ratio = Current Assets/Current Liabilities**

**Type of Long-Term Care (including ICF/DD) Facilities:**

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Not-For-Profit, System	1.5 or more
Not-For-Profit, Non-System	1.5 or more
For-Profit, System	1.5 or more
For-Profit, Non-System	1.5 or more
Governmental	1.5 or more

- 2) Net Margin Percentage = (Net Income/Net Operating Revenues) X 100

**Type of Long-Term Care (including ICF/DD) Facilities:**

Not-For-Profit, System	2.5% or more
Not-For-Profit, Non-system	2.5% or more
For-Profit, System	2.5% or more
For-Profit, Non-system	2.5% or more
Governmental	0% or more

HFSRB NOTE: Net Margin Percentage for For-Profits is before the provision for income taxes. Net income is the excess of revenues over expenses from operations, before non-recurring income or expense.

- 3) Long-Term Debt to Capitalization = (Long-Term Debt/Long-Term Debt plus Net Assets) X 100

**Type of Long-Term Care (including ICF/DD) Facilities:**

Not-For-Profit, System	80% or less
Not-For-Profit, Non-system	80% or less
For-Profit, System	50% or less
For-Profit, Non-system	50% or less
Governmental	NA

HFSRB NOTE: For long-term care facilities and for-profit facilities, the applicant shall explain the rationale of the use of debt rather than the issuance of stock (if this is the case).

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- 4)  $\text{Projected Debt Service Coverage} = \frac{\text{Net Income plus (Depreciation plus Interest plus Amortization)}}{\text{Principal Payments plus Interest Expense}}$  for the Year of Maximum Debt Service after Project Completion

**Type of Long-Term Care (including ICF/DD) Facilities:**

Not-For-Profit, System	1.5 or more
Not-For-Profit, Non-system	1.5 or more
For-Profit, System	1.5 or more
For-Profit, Non-system	1.5 or more
Governmental	1.5 or more

HFSRB NOTE: Net Income is the excess of revenues over expenses from operations, before non-recurring income or expense.

- 5)  $\text{Days Cash on Hand} = \frac{\text{Cash plus Investments plus Board Designated Funds}}{(\text{Operating Expense less Depreciation Expense})/365 \text{ days}}$

**Type of Long-Term Care (including ICF/DD) Facilities:**

Not-For-Profit, System	45 or more days
Not-For-Profit, Non-system	45 or more days
For-Profit, System	45 or more days
For-Profit, Non-system	45 or more days
Governmental	45 or more days

HFSRB NOTE: Days Cash on Hand ratio can be a combination of cash and investments held by the facilities or available funds from the backup line of credit.

- 6)  $\text{Cushion Ratio} = \frac{\text{Cash plus Investments plus Board Designated Funds}}{(\text{Principal Payments plus Interest Expense})}$  for the year of maximum debt service after project completion

**Type of Long-Term Care (including ICF/DD) Facilities:**

Not-For-Profit, System	3.0 or more
Not-For-Profit, Non-system	3.0 or more

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For-Profit, System	3.0 or more
For-Profit, Non-system	3.0 or more
Governmental	NA

HFSRB NOTE: The applicant may also include in the numerator the amount of funds available from an existing or proposed backup line of credit. If the applicant includes funds available from a line of credit, documentation shall be provided regarding the terms and conditions of the line.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Pick (N) Pools
- 2) Code Citation: 11 Ill. Adm. Code 308
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
308.20	Amend
308.40	Amend
308.90	Amend
- 4) Statutory Authority: 230 ILCS 5/9(b)
- 5) A Complete Description of the Subjects and Issues Involved: Currently Section 308.20 describes six methods for organization licensees to follow when conducting their Pick (N) Pool wagers. This proposed rulemaking adds a seventh method with a “unique winning ticket” provision. This wagering option was recently adopted by Gulfstream Park, calling it the “Rainbow 6”. Gulfstream saw an increase in the interest of the fans because of this rule.

This proposed rulemaking also repeals Sections 308.40(b) and 308.90(e). These subsections currently require that once wagering has closed for the first race of a Pick (n) Pool, if a race is moved from the turf course to the dirt track, then all ticket holders are considered winners for that race for the Pick (n) Pool. If this occurs in any leg of a Pick (n) Pool, the carryover from previous performances shall not be included in the distribution unless the pool has been designated as a mandatory distribution. The original rationale for implementing the surface change rule in Illinois was to protect the wagering public in the case of numerous scratches caused by a late surface change. With the introduction of a synthetic surface at Arlington Park, the number of horses scratched because of surface changes should be minimal, as the synthetic surface should handle the rain and remain “fast”. There is no longer a need for this rule.
- 6) Published studies or reports and sources of underlying data used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No

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- 10) Are there any other proposed rulemakings pending in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this notice, to:

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

312/814-5017

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

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

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED AMENDMENTS

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
 SUBTITLE B: HORSE RACING  
 CHAPTER I: ILLINOIS RACING BOARD  
 SUBCHAPTER a: GENERAL RULES

PART 308  
 PICK (N) POOLS

Section	
308.10	Pick (n)
308.20	Pool Calculations
308.30	Dead Heats
308.40	Scratches
308.50	Cancellation of Races
308.60	Carryover Cap
308.70	Mandatory Distribution
308.80	Disclosure
308.90	Pick 3 Pools

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

SOURCE: Adopted at 18 Ill. Reg. 7433, effective May 8, 1994; amended at 19 Ill. Reg. 5039, effective April 1, 1995; amended at 30 Ill. Reg. 6165, effective April 1, 2006; amended at 32 Ill. Reg. 10143, effective July 1, 2008; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

### Section 308.20 Pool Calculations

The organization licensee may select one of the following methods for conducting its Pick (n) pool. As used in this Part, "Major ~~pool~~Pool" is defined as ~~seventy-five~~75% of the daily net pool; and "Minor ~~pool~~Pool" is defined as ~~twenty-five~~25% of the daily net pool. Any deviation from the ~~major/minor~~Major/Minor pool percentage division must be approved by the State Director of ~~Mutuels~~Mutuel.

- a) Method 1, Pick (n) with Carryover: The net Pick (n) pool and carryover, if any, shall be distributed as a single price pool to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool shall be distributed as a single price pool to those who selected the first-place finisher in

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the greatest number of Pick (n) contests;<sup>5</sup> and the remainder shall be added to the carryover.

- b) Method 2, Pick (n) with Minor Pool and Carryover: The major share of the net Pick (n) pool and the carryover, if any, shall be distributed to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher of all Pick (n) contests, the minor share of the net Pick (n) pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests;<sup>5</sup> and the major share shall be added to the carryover.
- c) Method 3, Pick (n) with No Minor Pool and No Carryover: The net Pick (n) pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests, based upon the official order of finish. If there are no winning wagers, the pool is refunded.
- d) Method 4, Pick (n) with Minor Pool and No Carryover: The major share of the net Pick (n) pool shall be distributed to those who selected the first place finisher in the greatest number of Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in a second greatest number of Pick (n) contests, the minor share of the net Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests. If the greatest number of first-place finishers selected is one (1), the major and minor shares are combined for distribution as a single price pool. If there are no winning wagers, the pool is refunded.
- e) Method 5, Pick (n) with Minor Pool and No Carryover: The major share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in all Pick (n) contests, the entire net Pick (n) pool shall be distributed as a single

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price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests. If there are no wagers selecting the first-place finisher in a second greatest number of Pick (n) contests, the minor share of the net Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in each of the Pick (n) contests. If there are no winning wagers, the pool is refunded.

- f) Method 6, Pick (n) with Minor Pool and Carryover: The net Pick (n) pool and carryover, if any, shall be distributed to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in all Pick (n) contests, two-thirds of the net pool (major pool) or one-half of the total gross pool, whichever is greater, shall be distributed as a single price pool to those who present a valid pari-mutuel wager for that Pick (n) pool and the remaining one-third of the net pool shall be added to the carryover. The minimum pay-off provisions contained in 11 Ill. Adm. Code 405.130 shall not apply when distributing the major pool in this pool calculation.
- g) Method 7, Pick (n) with "Unique Winning Ticket" Provision: The net Pick (n) pool and carryover, if any, shall be distributed to the holder of a unique winning ticket that selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there is no unique winning ticket selecting the first-place finisher in each of the Pick (n) contests, or if there are no wagers selecting the first-place finisher of all Pick (n) contests, the minor share of the net Pick (n) pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests, and the major share shall be added to the carryover. Unique winning ticket, as used in this subsection, shall be defined as having occurred when there is one and only one winning ticket that correctly selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish, to be verified by the unique serial number assigned by the tote company that issued the winning ticket. In the event that there is more than one winning ticket that correctly selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish, the unique winning ticket shall be deemed to not have occurred.

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

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**Section 308.40 Scratches**

a) Should a betting interest in any of the Pick (n) contests be scratched, the actual favorite, as evidenced by total amounts wagered in the Win pool at the closing of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the Win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalizator shall produce reports showing each of the wagering combinations with substituted betting interests ~~that~~<sup>which</sup> became winners as a result of the substitution, in addition to the normal winning combination.

~~b) Once wagering has closed for the first race of a Pick (n) Pool, if a race is moved from the turf course to the dirt track, then all ticket holders are considered winners for that race of the Pick (n) Pool. The entire net pool shall be distributed as a single price pool to those whose selections finish first in the greatest number of Pick (n) contests. Any previous carryover shall not be included unless the pool has been designated as a mandatory distribution.~~

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

**Section 308.90 Pick 3 Pools**

- a) The Pick 3 requires selection of the first-place finisher in each of three specified contests.
- b) The net Pick 3 pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
  - 1) As a single price pool to those whose selection finished first in each of the three contests; but if there are no such wagers, then
  - 2) As a single price pool to those who selected the first-place finisher in any two of the three contests; but if there are no such wagers, then
  - 3) As a single price pool to those who selected the first-place finisher in any one of the three contests; but if there are no such wagers, then
  - 4) The entire pool shall be refunded on Pick 3 wagers for those contests.

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- c) If there is a dead heat for first in any of the three contests involving:
- 1) contestants representing the same betting interest, the Pick 3 pool shall be distributed as if no dead heat occurred.
  - 2) contestants representing two or more betting interests, the Pick 3 pool shall be distributed as a single price pool with each winning wager receiving an equal share of the profit.
- d) Should a betting interest in any of the Pick 3 contests be scratched, the actual favorite, as evidenced by total amounts wagered in the Win pool at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the Win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalizator shall produce reports showing each of the wagering combinations with substituted betting interests ~~that~~<sup>which</sup> became winners as a result of the substitution, in addition to the normal winning combination.
- ~~e) Once wagering has closed for the first race of a Pick (n) Pool, if a race is moved from the turf course to the dirt track, then all ticket holders are considered winners for that race for the Pick (n) Pool. If this occurs in any leg of a Pick (n) Pool, the carryover from previous performances shall not be included in the distribution unless the pool has been designated as a mandatory distribution.~~
- ef) If two or three Pick 3 contests are cancelled or declared "no contest", the entire pool shall be refunded on Pick 3 wagers for those contests.
- fg) If one of the Pick 3 contests is cancelled or declared "no contest", the Pick 3 pool will remain valid and shall be distributed in accordance with subsection (b)(2).

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

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- 1) Heading of the Part: Pentafecta
- 2) Code Citation: 11 Ill. Adm. Code 324
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
324.20	Amend
324.50	Amend
324.60	Repeal
- 4) Statutory Authority: 230 ILCS 5/9(b)
- 5) A Complete Description of the Subjects and Issues Involved: Currently Section 324.20 has three options for the distribution of winnings. This proposed rulemaking proposes to add a fourth option, the "unique winning wager." The unique winning ticket shall be one and only one winning ticket whose combination finished in correct sequence as the first five betting interests. Because there could be very limited play if there is no consolation payout, a consolation payout is proposed when it is hit by more than one winning ticket. The Pentafecta, also known as the High 5, has seen a decrease in popularity. Illinois would be the first state to adopt this "unique winning wager" provision.  
  
Section 324.50 currently requires a minimum of nine betting interests and in the event of a scratch, eight betting interests is permissible, provided there are no uncoupled entries. The Board proposes to lower the minimum to eight betting interests, scratch down to seven regardless of uncoupled entries for thoroughbred racing only. This is still one more betting interest required than the normal progression of five in a trifecta and six in a superfecta. Because of the carry-over provision of the wager, the Stewards will be permitted to authorize the wager on the closing day of a meet regardless of field size and couplings.  
  
This proposed rulemaking repeals Section 324.60. This Section describes minimum field sizes when there are coupled and uncoupled entries. The proposed rulemaking should help make the Pentafecta wager more successful.
- 6) Published studies or reports and sources of underlying data used to compose this rulemaking: None
- 7) Will proposed rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No

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- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this notice, to:
- Mickey Ezzo  
Illinois Racing Board  
100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601
- 312/814-5017
- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
- B) Reporting, bookkeeping or other procedures required for compliance: None
- C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: The Board did not anticipate the need for this rulemaking at that time.

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

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TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
 SUBTITLE B: HORSE RACING  
 CHAPTER I: ILLINOIS RACING BOARD  
 SUBCHAPTER a: GENERAL RULES

PART 324  
 PENTAFECTA

## Section

324.10	Pentafecta
324.20	Pool Distribution
324.30	Scratches
324.40	Dead Heats
324.50	Minimum Fields
324.60	Entries <u>(Repealed)</u>

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

SOURCE: Adopted by emergency rulemaking at 32 Ill. Reg. 7429, effective May 1, 2008, for a maximum of 150 days; adopted at 32 Ill. Reg. 10153, effective July 1, 2008; amended at 35 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 324.20 Pool Distribution**

The organization licensee may choose to distribute pools in accordance with subsection (a), (b), ~~or (c)~~ or (d). The organization licensee must give the Board 30 days notice if it chooses to distribute pools under subsection (b), ~~or subsection (c)~~ or subsection (d), including the exact percentages it will use to determine the minor and major pools if subsection (b) is used. The racing program shall indicate when the method described in subsection (b), ~~or subsection (c)~~ or subsection (d) is being used for a meet.

- a) Distribution of Winnings – Option 1  
 The net Pentafecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
- 1) As a single price pool to those whose combination finished in correct sequence as the first five betting interests, but if there are no such wagers, then

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- 2) As a single price pool to those whose combination included, in correct sequence, the first four betting interests, but if there are no such wagers, then
  - 3) As a single price pool to those whose combination included, in correct sequence, the first three betting interests, but if there are no such wagers, then
  - 4) As a single price pool to those whose combination included, in correct sequence, the first two betting interests, but if there are no such wagers, then
  - 5) As a single price pool to those whose combination correctly selected the first place betting interest only, but if there are no such wagers, then
  - 6) The entire pool shall be refunded on Pentafecta wagers for that contest.
- b) Distribution of Winnings – Option 2
- 1) The net Pentafecta pool shall be distributed to winning wagers in the following precedence, based on the official order of finish:
    - A) As a single price pool to those whose combination finished in correct sequence as the first five betting interests, but if there are no such wagers, then
    - B) The net pool will be divided into two separate pools. The major pool of the net pool shall be paid as a carryover pool into the next regularly scheduled Pentafecta race. The remaining minor pool shall be paid as a Pentafecta consolation pool, which will be equally divided among those ticket holders who correctly select the first four betting interests, but if there are no such wagers, then
    - C) The Pentafecta consolation pool will be divided among those ticket holders who correctly select the first three interests, but if there are no such wagers, then

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- D) The Pentafecta consolation pool will be divided among those ticket holders who correctly select the first two interests, but if there are no such wagers, then
  - E) The Pentafecta consolation pool will be divided among those ticket holders who correctly select the first betting interest, but if there are no such wagers, then
  - F) The entire net pool shall become a carryover pool into the next regularly scheduled Pentafecta race.
- 2) On the last Pentafecta race on the final day of the meeting, the net pool shall be redistributed using the method described in subsection (a).
- c) Distribution of Winnings – Option 3
- 1) The net Pentafecta pool shall be distributed to winning wagers in the following precedence, based on the official order of finish:
    - A) As a single price pool to those whose combination finished in correct sequence as the first five betting interests, but if there are no such wagers, then
    - B) The entire net pool shall be paid as a carryover pool into the next regularly scheduled Pentafecta race.
  - 2) On the last Pentafecta race on the final day of the meeting, the net pool shall be redistributed using the method described in subsection (a).
- d) Distribution of Winnings – Option 4
- 1) The net Pentafecta pool shall be distributed to winning wagers in the following precedence, based on the official order of finish:
    - A) As a single price pool to the holder of a unique winning ticket whose combination finished in correct sequence as the first five betting interests, but if there is no such unique winning ticket, then

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- B) The net pool will be divided into two separate pools. The major pool of the net pool shall be paid as a carryover pool into the next regularly scheduled Pentafecta race. The remaining minor pool shall be paid as a Pentafecta consolation pool, which will be equally divided among those ticket holders who correctly select the first five interests, but if there are no such wagers, then
- C) The entire net pool shall become a carryover pool into the next regularly scheduled Pentafecta race.
- 2) Unique winning ticket, as used in subsection (d)(1), shall be defined as having occurred when there is one and only one winning ticket whose combination finished in correct sequence as the first five betting interests, to be verified by the unique serial number assigned by the tote company that issued the winning ticket. In the event that there is more than one winning ticket whose combination finished in correct sequence as the first five betting interests, the unique winning ticket shall be deemed to not have occurred.
- 3) On the last Pentafecta race on the final day of the meeting, the net pool shall be redistributed using the method described in subsection (a).
- ed) If fewer than five betting interests finish and the contest is declared official, payoffs will be made based upon the order of finish of those betting interests completing the contest. The balance of any selection beyond the number of betting interests completing the contest shall be ignored. If the pools are being distributed under either subsection (b) or subsection (c), any previous Pentafecta contest's carryover will not be included in the payoff and will be retained for the next contest's carryover, and this contest's net Pentafecta pool will be distributed using the method described in subsection (a).

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

**Section 324.50 Minimum Fields**

- a) Pentafecta wagering shall not be scheduled on a harness race unless at least nine betting interests are carded. In the event of a scratch, Pentafecta wagering on a race in which eight betting interests remain is permissible, ~~provided there are no uncoupled entries.~~

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- b) Pentafecta wagering shall not be scheduled on a thoroughbred race unless at least eight betting interests are carded. In the event of a scratch, Pentafecta wagering on a race in which seven betting interests remain is permissible.
- ~~cb)~~ This Section shall not be applicable to stakes races.
- d) Upon the approval of the Stewards, this Section shall not be applicable on the closing day of a meet to ensure the payout of the carryover.

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

**Section 324.60 Entries (Repealed)**

- a) ~~Entries, either coupled or uncoupled, shall be allowed in a Pentafecta race under the following conditions:~~
- ~~1) one entry requires at least nine betting interests at the start of the race, except, in the event of a scratch, Section 324.50(a) applies.~~
  - ~~2) two entries requires at least ten betting interests at the start of the race.~~
  - ~~3) more than two entries shall require approval from the Stewards.~~
- b) ~~For stakes races with a minimum purse of \$20,000, entries, either coupled or uncoupled, shall be allowed and there shall be no restrictions on minimum betting interests.~~
- e) ~~For stakes races with a minimum purse of \$100,000, common owner entries, either coupled or uncoupled, shall be allowed and there shall be no restrictions on minimum betting interests.~~
- d) ~~This Section shall not apply to races that are permitted for simulcasting under Section 26(g) of the Act [230 ILCS 5/26(g)] or for uncoupled entries permitted in 11 Ill. Adm. Code 1413.114(c) when there are thoroughbred stakes races with purses of \$250,000 or more.~~

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

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Quinella Double
- 2) Code Citation: 11 Ill. Adm. Code 326
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
326.10	New
326.20	New
326.30	New
326.40	New
326.50	New
- 4) Statutory Authority: 230 ILCS 5/9(b)
- 5) A Complete Description of the Subjects and Issues Involved: This proposed wager is identical to the Racing Commissioners International model rule. The Quinella Double wager requires selection of the first two runners in a race, regardless of order, in two races. The Quinella Double and its predecessor the "Big-Q" were offered at Sportsman's Park in the late 1960's and Maywood Park in the 1990's. This wager is likely to introduce the novice players to more challenging and rewarding wagers.
- 6) Published studies or reports and sources of underlying data used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending in this Part? No
- 11) Statement of Statewide Policy Objectives: No local governmental units will be required to increase expenditures.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Written comments should be submitted, within 45 days after this Notice, to:

Mickey Ezzo  
Illinois Racing Board

ILLINOIS RACING BOARD

NOTICE OF PROPOSED RULES

100 West Randolph  
Suite 7-701  
Chicago, Illinois 60601

(312) 814-5017

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

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

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED RULES

TITLE 11: ALCOHOL, HORSE RACING, AND LOTTERY  
SUBTITLE B: HORSE RACING  
CHAPTER I: ILLINOIS RACING BOARD  
SUBCHAPTER a: GENERAL RULESPART 326  
QUINELLA DOUBLE

Section	
326.10	General
326.20	Pool Distribution
326.30	Dead Heats
326.40	Scratches
326.50	Race Cancelled

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

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

**Section 326.10 General**

The Quinella Double requires selection of the first two finishers, irrespective of order, in each of two specified contests.

**Section 326.20 Pool Distribution**

The net Quinella Double pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

- a) If a coupled entry or mutuel field finishes as the first two contestants in either contest, as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest, as well as the first two finishers in the alternate Quinella Double contest; otherwise
- b) As a single price pool to those who selected the first two finishers in each of the two Quinella Double contests; but if there are no such wagers, then

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED RULES

- c) As a profit split to those who selected the first two finishers in either of the two Quinella Double contests; but if there are no such wagers on one of those contests, then
- d) As a single price pool to those who selected the first two finishers in the one covered Quinella Double contest; but if there were no such wagers, then
- e) The entire pool shall be refunded on Quinella Double wagers for those contests.

**Section 326.30 Dead Heats**

- a) If there is a dead heat for first in either of the two Quinella Double contests involving:
  - 1) contestants representing the same betting interest, the Quinella Double pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest.
  - 2) contestants representing two betting interests, the Quinella Double pool shall be distributed as if no dead heat occurred.
  - 3) contestants representing three or more betting interests, the Quinella Double pool shall be distributed as a profit split.
- b) If there is a dead heat for second in either of the Quinella Double contests involving contestants representing the same betting interest, the Quinella Double pool shall be distributed as if no dead heat occurred.
- c) If there is a dead heat for second in either of the Quinella Double contests involving contestants representing two or more betting interests, the Quinella Double pool shall be distributed as a profit split.

**Section 326.40 Scratches**

- a) Should a betting interest in the first half of the Quinella Double be scratched prior to the first Quinella Double contest being declared official, all money wagered on combinations including the scratched betting interest shall be deducted from the Quinella Double pool and refunded.

## ILLINOIS RACING BOARD

## NOTICE OF PROPOSED RULES

- b) Should a betting interest in the second-half of the Quinella Double be scratched prior to the close of wagering on the first Quinella Double contest, all money wagered on combinations including the scratched betting interest shall be deducted from the Quinella Double pool and refunded.
- c) Should a betting interest in the second half of the Quinella Double be scratched after the close of wagering on the first Quinella Double contest, all wagers combining the winning combination in the first contest with a combination including the scratched betting interest in the second contest shall be allocated a consolation payout. In calculating the consolation payout, the net Quinella Double pool shall be divided by the total amount wagered on the winning combination in the first contest and an unbroken consolation price obtained. The unbroken consolation price is multiplied by the dollar value of wagers on the winning combination in the first contest combined with a combination including the scratched betting interest in the second contest to obtain the consolation payout. Breakage is not declared in this calculation. The consolation payout is deducted from the net Quinella Double pool before calculation and distribution of the winning Quinella Double payout. In the event of a dead heat involving separate betting interests, the net Quinella Double pool shall be distributed as a profit split.

**Section 326.50 Race Cancelled**

- a) If either of the Quinella Double contests is cancelled prior to the first Quinella Double contest, or the first Quinella Double contest is declared "no contest", the entire Quinella Double pool shall be refunded on Quinella Double wagers for those contests.
- b) If the second Quinella Double contest is cancelled or declared "no contest" after the conclusion of the first Quinella Double contest, the net Quinella Double pool shall be distributed as a single price pool to wagers selecting the winning combination in the first Quinella Double contest. If there are no wagers selecting the winning combination in the first Quinella Double contest, the entire Quinella Double pool shall be refunded on Quinella Double wagers for those contests.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Professional Counselor and Clinical Professional Counselor Licensing Act
- 2) Code Citation: 68 Ill. Adm. Code 1375
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
1375.30	Amendment
1375.40	Repealed
1375.45	New Section
1375.50	Repealed
1375.60	Amendment
1375.70	Amendment
1375.80	Amendment
1375.120	Amendment
1375.130	Amendment
1375.140	Repealed
1375.145	New Section
1375.150	Amendment
1375.160	Amendment
1375.170	Amendment
1375.200	Amendment
1375.205	Amendment
1375.210	Amendment
1375.220	Amendment
1375.225	Amendment
1375.230	Amendment
1375.APPENDIX A	Amendment
1375.APPENDIX B	Amendment
- 4) Statutory Authority: Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]
- 5) Effective Date of Amendments: May 13, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Date Notice of Proposal Published in Illinois Register: December 17, 2010; 34 Ill. Reg. 19270
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences between proposal and final version: No substantive changes; a few technical changes and clarifications have been made.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: The adopted amendments are primarily clean up, including removal of obsolete grandfather provisions. Changes to the educational sections have been made in accordance with Public Act 96-1139 to clarify and simplify the language and reduce confusion by applicants and educational institutions. Additional clean up changes have been made and other changes made to reflect standard Department language and procedures.
- 16) Information and questions regarding this rulemaking shall be directed to:

Department of Financial and Professional Regulation  
Attention: Craig Cellini  
320 West Washington, 3rd Floor  
Springfield, Illinois 62786

217/785-0813 Fax #: 217/557-4451

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

## TITLE 68: PROFESSIONS AND OCCUPATIONS

## CHAPTER VII: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## SUBCHAPTER b: PROFESSIONS AND OCCUPATIONS

## PART 1375

PROFESSIONAL COUNSELOR AND CLINICAL PROFESSIONAL  
COUNSELOR LICENSING ACT

## SUBPART A: LICENSED PROFESSIONAL COUNSELOR

## Section

1375.10	Temporary License as a Professional Counselor (Repealed)
1375.20	How to Obtain a Permanent License as a Professional Counselor After Receiving a Temporary License (Repealed)
1375.30	Application for Examination/Permanent Licensure as a Professional Counselor
1375.40	Professional Experience for Licensure as a Professional Counselor after December 31, 1998 <u>(Repealed)</u>
<u>1375.45</u>	<u>Professional Education for Professional Counselor License</u>
1375.50	Approved Professional Counseling Programs <u>(Repealed)</u>
1375.60	Examination – Professional Counselor
1375.70	Endorsement – Professional Counselor
1375.80	Restoration – Professional Counselor

## SUBPART B: LICENSED CLINICAL PROFESSIONAL COUNSELOR

## Section

1375.100	Temporary License as a Clinical Professional Counselor (Repealed)
1375.110	How to Obtain a Permanent License as a Clinical Professional Counselor After Receiving a Temporary License (Repealed)
1375.120	Application for Examination/Permanent Licensure as a Clinical Professional Counselor
1375.130	Professional Experience for Licensure as a Clinical Professional Counselor <u>Beginning January 1, 1999</u>
1375.135	Clinical Professional Counselor Licenses for Clinical Psychologists and Clinical Social Workers
1375.140	Approved Clinical Professional Counseling Programs <u>(Repealed)</u>
<u>1375.145</u>	<u>Professional Education for Clinical Professional Counseling Programs</u>
1375.150	Examination – Clinical Professional Counselor
1375.160	Endorsement – Clinical Professional Counselor

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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1375.170 Restoration – Clinical Professional Counselor

## SUBPART C: GENERAL

## Section

1375.200 Renewals  
1375.205 Fees  
1375.210 Inactive Status  
1375.220 Continuing Education  
1375.225 Unprofessional Conduct  
1375.230 Granting Variances

1375.APPENDIX A Course Descriptions

1375.APPENDIX B Education, Experience and Examination History

AUTHORITY: Implementing the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)].

SOURCE: Adopted at 18 Ill. Reg. 18018, effective December 12, 1994; amended at 22 Ill. Reg. 8460, effective May 4, 1998; amended at 24 Ill. Reg. 7335, effective May 1, 2000; emergency amendment at 26 Ill. Reg. 18488, effective December 16, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 5848, effective March 24, 2003; amended at 27 Ill. Reg. 15483, effective September 19, 2003; amended at 28 Ill. Reg. 16277, effective December 2, 2004; amended at 35 Ill. Reg. 7586, effective May 13, 2011.

## SUBPART A: LICENSED PROFESSIONAL COUNSELOR

**Section 1375.30 Application for Examination/Permanent Licensure as a Professional Counselor**

- a) Each applicant seeking original licensure under Section 35 of the Act shall file an application with the Department of Financial and Professional Regulation-Division of Professional Regulation (Division), on forms provided by the DivisionDepartment, ~~at least 90 days prior to an examination date~~. The application shall include:

- 1) ~~For individuals who graduated or who were enrolled in a program prior to January 1, 1999 (these individuals have until January 1, 2003 to complete~~

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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~~the educational requirements set forth in Section 1375.50(a); otherwise, the applicant will be required to meet the educational requirements set forth in Section 1375.50(b)):~~ A) Certification of education from a master's degree program or doctoral degree program in counseling, psychology or rehabilitation counseling from a college, university or school that is a regionally accredited institution of higher education and recognized by the U.S. Department of Education~~recognized by the educational governing authority in the jurisdiction in which it is located~~, or certification of education graduation and an official transcript from a similar master's degree or doctoral degree program approved by the Department in accordance with Section 1375.45(c)~~1375.50(b)~~ of this Part. ~~;~~ ~~or~~

B) ~~Certification of a baccalaureate degree from a college, university or school recognized by the educational governing authority in the jurisdiction in which it is located and 5 years of full time satisfactory supervised experience as a professional counselor subsequent to the degree in accordance with Section 1375.40 of this Part. However, experience earned prior to January 1, 1999 shall meet the following requirements:~~

- i) ~~An applicant shall document a total of 8400 clock hours of experience. No more than 1680 clock hours may be counted toward one year of experience. Part time experience shall be counted toward the experience requirement.~~
- ii) ~~The supervisor shall document the experience as satisfactory or better.~~
- iii) ~~Supervised work experience, for purposes of this Section, shall entail services to individuals, couples, groups, families and organizations in any one or more of the fields of professional counseling defined in Section 10 of the Act.~~
- iv) ~~Qualified supervisors are those individuals who, at the time of supervision, were master's level or doctoral level counselors (such as, but not limited to, licensed or registered marriage and family therapists, registered art therapists, pastoral counselors, school counselors, school~~

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~~social workers, school psychologists, certified rehabilitation counselors), certified social workers or licensed clinical social workers, licensed clinical psychologists or licensed/registered psychologists, psychiatrists defined in Section 1-121 of the Mental Health and Developmental Disabilities Code or licensed clinical professional counselors.~~

- ~~v) An applicant may substitute, one time only, 15 semester hours or equivalent quarter hours of graduate courses related to counseling for one year of satisfactory supervised training.~~
- ~~vi) An applicant may begin gaining the required experience upon completion of the degree requirements. Verification of the date of completion of the degree, when different from the date of graduation, shall be certified to the Department by the applicant's educational institution.~~

2) ~~Beginning January 1, 1999:~~

- ~~A) Certification of education and an official transcript from a master's or doctoral degree program in counseling, psychology, rehabilitation counseling or similar degree program approved in accordance with Section 1375.50(b) of this Part; or~~
- ~~B) Certification of education and an official transcript from a baccalaureate program in human services or similar degree program approved by the Department in accordance with Section 1375.50(b) of this Part and documentation of completion of 5 years of supervised professional experience subsequent to the degree in accordance with Section 1375.40 of this Part.~~

3) ~~Beginning January 1, 2005:~~

- ~~A) Certification of education and an official transcript from a master's or doctoral degree program in counseling, psychology, rehabilitation counseling or similar degree program approved in accordance with Section 1375.50(c) of this Part; or~~

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- ~~B)~~ ~~Certification of education and an official transcript from a baccalaureate program in human services or similar degree program approved by the Department in accordance with Section 1375.50(c) of this Part and documentation of completion of 5 years of supervised professional experience subsequent to the degree in accordance with Section 1375.40 of this Part.~~
- 4) ~~A complete work history since receipt of a qualifying degree for licensure (baccalaureate, master's or doctorate degree).~~
- ~~2)5)~~ The required fee set forth in Section 1375.205.
- ~~3)6)~~ Certification of licensure, on forms provided by the ~~Division~~Department, from the state or territory of the United States in which an applicant was originally licensed and the state in which the applicant predominantly practices and is currently licensed, if applicable, stating:
- A) The time during which the applicant was licensed in that jurisdiction, including the date of the original issuance in that jurisdiction;
- B) A description of the examination in that jurisdiction; and
- C) Whether the file on the applicant contains any record of disciplinary actions taken or pending.
- b) Any individual who applies for a professional counselor license after January 1, 2008 shall meet the educational requirements set forth in Section ~~1375.45(a), 1375.50(e) (48 semester hours and 1 course in each area), e)~~
- 1) Individuals applying for licensure as a professional counselor may submit one of the following certifications (based on examination), in lieu of the documents required in ~~subsections~~subsections (a)(1) ~~and (2)~~:
- A1) Commission on Rehabilitation Counselor Certification (CRC);
- B2) National Certified Counselors (NCC);

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2) An applicant submitting one of the certifications listed in subsection (b)(1) above will not be required to take and pass an additional examination administered by the Division~~Department~~. The Division~~Department~~, upon recommendation of the Professional Counselor Licensing and Disciplinary Board (Board), has determined that the education and examination requirements are equivalent to the requirements for licensure as a professional counselor.

~~d) The Department, upon recommendation of the Board, has determined that the educational requirements of the following certifications meet the standards for an applicant to sit for the examination:~~

~~1) Clinical Member of the American Association of Marriage and Family Therapy (AAMFT);~~

~~2) Type 73 certificate issued by the Illinois State Board of Education as a School Counselor if the holder of the certificate has graduated from a Council for Accreditation of Counseling and Related Educational Programs (CACREP) school counseling program or meets the educational standards set forth in Section 1375.50, School Psychologist or School Social Worker;~~

~~3) Fellow or Diplomate of the American Association of Pastoral Counselors (AAPC).~~

~~An applicant who holds certification in any of the above groups needs to submit a copy of a certification in lieu of the documents required in subsections (a)(1) and (2). All certifications accepted by the Department shall be current.~~

c)e) When the accuracy of any submitted documentation or the relevance or sufficiency of the coursework or experience is questioned by the Division~~Department~~ or the Board because of lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking licensure shall be requested to:

1) Provide such information as may be necessary; and/or

2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information or clear up any discrepancies or conflicts

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in information.

- ~~d)†~~ If an applicant has taken and passed the examination in accordance with Section ~~1375.60~~1375.50, the applicant shall file an application in accordance with subsection (a) ~~above~~ and shall have the examination scores submitted to the ~~Division~~Department directly from the testing entity or from the state of original licensure.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.40 Professional Experience for Licensure as a Professional Counselor after December 31, 1998 (Repealed)**

- a) ~~Persons applying for licensure as professional counselors after December 31, 1998, who hold a baccalaureate degree in human services or similar degree program that meets the requirements set forth in Section 1375.50, shall be required to complete 5 years of satisfactory supervised professional experience as follows:~~
- ~~1) One year of experience shall be a maximum of 1680 clock hours obtained in not less than 48 weeks. A total of 8400 clock hours is required. No more than 1680 clock hours may be counted toward one year of experience. Part time experience shall be counted toward the experience requirement.~~
  - ~~2) 15 semester hours or equivalent quarter hours of graduate courses related to counseling may be substituted one time for one year of work experience.~~
  - ~~3) Supervised experience shall be experience obtained under a qualified supervisor and entail the provision of services to individuals, couples, groups, families and organizations in any one or more of the fields of professional counseling defined in Section 10 of the Act.~~
  - ~~4) A qualified supervisor means any person who is a licensed clinical professional counselor, licensed clinical social worker, licensed clinical psychologist, or psychiatrist as defined in Section 1-121 of the Mental Health and Developmental Disabilities Code. If supervision took place outside Illinois, the supervisor shall be a master's level or doctoral level~~

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- ~~counselor engaged in clinical professional counseling. The supervisor shall hold a license if the jurisdiction in which the supervisor practices requires licensure.~~
- ~~5) The supervisor shall have met with the applicant at least one hour each week.~~
- ~~6) The experience shall have been evaluated by the supervisor as satisfactory or better.~~
- ~~7) The supervisor may be provided at the applicant's place of work or may be hired by the applicant to provide supervision.~~
- ~~8) The counseling activities must be performed pursuant to the supervisor's order, control, oversight, guidance and full professional responsibility.~~
- b) ~~An applicant may begin gaining the required experience upon completion of the degree requirements. Verification of the date of completion of the degree, when different from the date of graduation, shall be certified to the Department by the applicant's educational institution.~~
- e) ~~A person holding a master's degree or doctorate in the field of counseling, rehabilitation counseling, psychology or similar degree program shall not be required to document experience to qualify for licensure as a professional counselor.~~

(Source: Repealed at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.45 Professional Education for Professional Counselor License**

- a) The educational requirements are as follows:
- 1) Masters and Doctoral degrees shall be from a college, university or school that is a regionally accredited institution of higher education and recognized by the U.S. Department of Education;
- 2) The programs, wherever they may be administratively housed, must be clearly identified and labeled as offering counseling, rehabilitation counseling, psychology programs, or similar degree programs. Such a

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program must specify in institutional catalogues and brochures its intent to educate and train counselors;

- 3) The program is an organizational entity within the institution;
- 4) The program has an integrated, organized sequence of study;
- 5) The program must be at least 2 academic years in length and require an individual to graduate from a program with a minimum of 48 semester hours or 72 quarter hours with a minimum of one course ("course" is defined as 3 semester hours or 4.5 quarter hours equivalent) in each of the areas listed in this subsection (a)(5). The definition of a minimum of one course means that the objectives and content of one course cannot be used to meet the objectives and content of another course. (See Appendix A (Course Descriptions) for a definition of the subject content for each core area with examples of course titles that relate to each of the core content areas.)
  - A) Human Growth and Development
  - B) Counseling Theory
  - C) Counseling Techniques
  - D) Group Dynamics, Processing and Counseling
  - E) Appraisal of Individuals
  - F) Research and Evaluation
  - G) Professional, Legal and Ethical Responsibilities Relating to Professional Counseling, Including Illinois Law
  - H) Social and Cultural Foundations
  - I) Lifestyle and Career Development
  - J) Practicum/Internship

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- K) Psychopathology and Maladaptive Behavior
- L) Substance Abuse
- M) Family Dynamics;
- 6) The program has faculty responsible for the program and has a sufficient number of full-time instructors to make certain that the educational obligations to the student are fulfilled;
- 7) The program has an identifiable body of students who are matriculated in that program for a degree;
- 8) The program has a one year residence. Residence requires interaction with faculty and other matriculated students. One year's residence is defined as 24 semester hours taken on a full-time or part-time basis at the institution accumulated within the time frame and course of study of the program.
- b) For the purpose of this Section, course shall be defined as an integrated, organized course of study that encompasses a minimum of one school semester or equivalent hours. No student designed courses, independent study courses, workshops or correspondence courses may be used to satisfy the core courses.
- c) The Division, upon recommendation of the Board, has determined that all master's degree and doctoral programs in professional counseling or rehabilitation counseling that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Council on Rehabilitation Education (CORE) and doctoral programs in psychology approved by the American Psychological Association and the Council for the National Registry of Health Service Providers are approved programs.
- d) Individual Program Requirements:
  - 1) Individuals applying for licensure as a professional counselor who have not graduated from a program listed in subsection (c) shall submit their official transcripts and program materials to the Division for evaluation by the Board to determine if they meet the requirements of this Section.

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- 2) Individuals applying for licensure who are deficient in any of the content areas set forth in subsection (a)(5) may complete any content area deficiencies in a graduate counseling, rehabilitation counseling, psychology, or similar degree program. No student designed courses, independent study courses, workshops or correspondence courses may be used to satisfy the core courses. The applicant will be required to submit proof to the Division that he or she has passed such a course and/or the experience. The proof shall include syllabi, course descriptions and official transcript.
- e) After January 1, 2008, all applicants will be required to meet the curriculum requirements set forth in this Section.

(Source: Added at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.50 Approved Professional Counseling Programs (Repealed)**

- a) ~~The Department of Financial and Professional Regulation Division of Professional Regulation shall approve similar degree programs (baccalaureate, master's, doctoral degree), on or before December 31, 1998, utilizing the following criteria:~~
- 1) ~~The program shall be located in a college, university or school recognized by the education accrediting authority in the jurisdiction in which it is located.~~
- 2) ~~The program shall require an individual to complete a minimum of 30 semester hours or equivalent quarter hours in any of the following 13 core areas described in more detail in Appendix A of this Part:~~
- A) ~~Human Growth and Development and Maladaptive Behavior~~
- B) ~~Counseling Theory~~
- C) ~~Counseling Techniques~~
- D) ~~Group Dynamics, Processing and Counseling~~
- E) ~~Appraisal of Individuals~~

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- ~~F) Research and Evaluation~~
  - ~~G) Professional, Legal and Ethical Responsibilities relating to professional counseling, especially as related to Illinois law~~
  - ~~H) Social and Cultural Foundations~~
  - ~~I) Lifestyle and Career Development~~
  - ~~J) Practicum~~
  - ~~K) Counseling Education~~
  - ~~L) Counseling Supervision~~
  - ~~M) Counseling Administration.~~
- b) ~~Beginning January 1, 1999, the Division shall, upon the recommendation of the Professional Counselor Examining and Disciplinary Board, approve baccalaureate programs in human services or similar degree programs at the baccalaureate level or counseling, rehabilitation counseling, psychology, or similar degree programs at the master's or doctoral level if they meet the following requirements:~~
- ~~1) The institution is a regionally accredited institution of higher education,~~
  - ~~2) The program, wherever it may be administratively housed, must be clearly identified and labeled as offering counseling, rehabilitation counseling, psychology or similar programs. Such a program must specify in institutional catalogues and brochures its intent to educate and train counselors or the institution grants a baccalaureate human services degree,~~
  - ~~3) The program is an organizational entity within the institution,~~
  - ~~4) The program has an integrated, organized sequence of study at least 2 academic years in length and must require an individual to complete a minimum of 48 semester hours or equivalent quarter hours with a course in at least 10 of the 16 core areas listed below:~~

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- A) ~~Human Growth and Development~~
  - B) ~~Counseling Theory~~
  - C) ~~Counseling Techniques~~
  - D) ~~Group Dynamics, Processing and Counseling~~
  - E) ~~Appraisal of Individuals~~
  - F) ~~Research and Evaluation~~
  - G) ~~Professional, Legal and Ethical Responsibilities relating to professional counseling, especially as related to Illinois law~~
  - H) ~~Social and Cultural Foundations~~
  - I) ~~Lifestyle and Career Development~~
  - J) ~~Practicum~~
  - K) ~~Counseling Education~~
  - L) ~~Counseling Supervision~~
  - M) ~~Counseling Administration~~
  - N) ~~Family Dynamics~~
  - O) ~~Psychopathology and Maladaptive Behavior~~
  - P) ~~Substance Abuse;~~
- 5) ~~The program has faculty responsible for the program and has a sufficient number of full-time instructors to make certain that the educational obligations to the student are fulfilled;~~
- 6) ~~The program has an identifiable body of students who are matriculated in that program for a degree;~~

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- ~~7) The program has a one year residence. Residence requires interaction with faculty and other matriculated students. One year's residence is defined as 24 semester hours taken on a full-time or part-time basis at the institution accumulated within the time frame and course of study of the program.~~
- e) Beginning January 1, 2005, the Division shall, upon the recommendation of the Professional Counselor Examining and Disciplinary Board, approve baccalaureate programs in human services or similar degree programs at the baccalaureate level, or counseling, rehabilitation counseling, psychology, or similar degree programs at the master's or doctoral level, if they meet the following requirements:
- 1) The institution is a regionally accredited institution of higher education;
  - 2) The program, wherever it may be administratively housed, must be clearly identified and labeled as offering counseling, rehabilitation counseling, psychology or similar programs. Such a program must specify in institutional catalogues and brochures its intent to educate and train counselors or that the institution grants a baccalaureate human services degree;
  - 3) The program is an organizational entity within the institution;
  - 4) The program has an integrated, organized sequence of study at least 2 academic years in length and requires an individual to complete a minimum of 48 semester hours or equivalent quarter hours with a minimum of one course (beginning January 1, 2008, "course" is defined as 3 semester hours or equivalent) in each of the following areas (described in more detail in Appendix A of this Part):
    - A) Human Growth and Development
    - B) Counseling Theory
    - C) Counseling Techniques
    - D) Group Dynamics, Processing and Counseling

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- E) ~~Appraisal of Individuals~~
- F) ~~Research and Evaluation~~
- G) ~~Professional, Legal and Ethical Responsibilities relating to professional counseling, especially as related to Illinois law~~
- H) ~~Social and Cultural Foundations~~
- I) ~~Lifestyle and Career Development~~
- J) ~~Practicum/Internship~~
- K) ~~Psychopathology and Maladaptive Behavior~~
- L) ~~Substance Abuse~~
- M) ~~Family Dynamics;~~
- 5) ~~The program has faculty responsible for the program and has a sufficient number of full-time instructors to make certain that the educational obligations to the student are fulfilled;~~
- 6) ~~The program has an identifiable body of students who are matriculated in that program for a degree;~~
- 7) ~~The program has a one year residence. Residence requires interaction with faculty and other matriculated students. One year's residence is defined as 24 semester hours taken on a full-time or part-time basis at the institution, accumulated within the time frame and course of study of the program.~~
- d) ~~Reevaluation of an Approved Program~~
- 1) ~~The Division may reevaluate any approved program at any time if it has reason to believe that the program has failed to continue to satisfy the minimum requirements of this Section or that the Division's decision to approve a program was based upon false, deceptive or incomplete information.~~

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- ~~2) A program whose approval is being reevaluated by the Division shall be given at least 15 days written notice prior to any recommendation by the Board and may either submit written comments or request a hearing before the Board.~~
- e) ~~For the purposes of this Section, course shall be defined as an integrated, organized course of study which encompasses a minimum of one school semester or equivalent hours. No workshops, student designed courses, independent study courses or correspondence courses may be used to satisfy the core courses.~~
- f) ~~The Division, upon recommendation of the Board, has determined that all master's degree and doctoral programs in professional counseling that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council on Rehabilitation Education (CORE) are approved. All doctoral programs in psychology of the American Psychological Association or the Council for the National Register of Health Service Providers in Psychology are approved.~~
- g) ~~Individual Program Requirements~~
- 1) ~~Individuals applying for licensure as a professional counselor who have not graduated from a program approved by the Division shall submit their transcripts and program materials to the Division for evaluation by the Board to determine if they meet the requirements of this Section.~~
- 2) ~~Individuals applying for licensure who are deficient in any of the core content areas in subsection (b)(4) may complete any of these courses in a counseling, rehabilitation counseling, psychology or similar degree program from an accredited institution. The applicant will be required to submit proof to the Division that he/she has passed such a course. Proof may include, but not be limited to, transcripts, curriculum and course materials.~~
- 3) ~~Individuals who are admitted to a degree program prior to January 1, 1999 have until January 1, 2003 to meet the educational requirements set forth in subsection (a) of this Section. After that date the applicant will be required to meet the curriculum requirements set forth in subsection (b) of this Section.~~

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- 4) ~~After January 1, 2008, all applicants will be required to meet the curriculum requirements set forth in subsection (c) of this Section.~~

(Source: Repealed at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.60 Examination – Professional Counselor**

- a) The examination administered by the ~~Division~~Department for licensure as a professional counselor shall be the National Counselor Examination (NCE) of the National Board for Certified Counselors (NBCC). The passing score on the examination shall be the passing score established by the testing entity.
- b) The ~~Division~~Department also shall accept passage of the Certified Rehabilitation Counselor Examination of the Commission on Rehabilitation Counselor Certification (CRCC). The passing scores on the examinations shall be the passing scores established by the testing entity.
- e) ~~The Department shall accept the National Counseling Examination (NCE) taken and passed, according to Department standards, in Illinois or in another jurisdiction.~~

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.70 Endorsement – Professional Counselor**

- a) Each applicant seeking licensure under Section 70 of the Act shall file an application with the ~~Division~~Department on forms provided by the ~~Division~~Department. The application shall include:
- 1) ~~Beginning January 1, 1999: A)~~Certification of education and an official transcript from a master's or doctoral degree program in counseling, psychology, rehabilitation counseling from a college, university or school accredited by an accrediting agency recognized by the U.S. Department of Education or similar degree program approved in accordance with Section ~~1375.45-1375.50(b) of this Part; or~~
- ~~B) Certification of education and an official transcript from a baccalaureate program in human services or similar degree program approved by the Department in accordance with Section~~

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~~1375.50 of this Part and documentation of completion of 5 years of supervised professional experience in accordance with Section 1375.40 of this Part.~~

2) ~~Beginning January 1, 2005:~~

A) ~~Certification of education and an official transcript from a master's or doctoral degree program in counseling, psychology, rehabilitation counseling or similar degree program approved in accordance with Section 1375.50(c) of this Part; or~~

B) ~~Certification of education and an official transcript from a baccalaureate program in human services or similar degree program approved by the Department in accordance with Section 1375.50(c) of this Part and documentation of completion of 5 years of supervised professional experience in accordance with Section 1375.40 of this Part.~~ 4) Successful completion of the professional counselor examination set forth in Section 1375.60 ~~of this Part.~~

~~3)5) The required fee set forth in Section 1375.205.;~~

~~4)6) Certification, on forms provided by the ~~Division~~Department, from the state or territory of the United States or jurisdiction in which the applicant was originally licensed and the state or jurisdiction in which the applicant is currently licensed, if applicable, stating:~~

A) The time during which the applicant was licensed in that jurisdiction, including the date of the original issuance of the license;

B) A description of the examination in that jurisdiction; and

C) Whether the file on the applicant contains any record of disciplinary actions taken or pending.

b) When the accuracy of any submitted documentation or the relevance or sufficiency of the coursework or experience is questioned by the ~~Division~~Department or the Board because of lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking

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licensure shall be requested to:

- 1) Provide such information as may be necessary; and/or
- 2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information or clear up any discrepancies or conflicts in information.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.80 Restoration – Professional Counselor**

- a) Any professional counselor whose license has expired or has been placed on inactive status for 5 years or less may have the license restored by paying the fees required by Section 1375.205. Individuals restoring ~~after March 31, 1999~~ will be required to submit proof of having met the continuing education requirements pursuant to Section 1375.220. Continuing education must be completed during the 24 months preceding application for restoration.
- b) Any person seeking restoration of a license that has been expired or placed on inactive status for more than 5 years shall file an application, on forms supplied by the ~~Division~~Department together with the fee required by Section 1375.205. Individuals restoring ~~after March 31, 1999~~ will be required to submit proof of having met the continuing education requirements pursuant to Section 1375.220. Continuing education must be completed during the 24 months preceding application for restoration. The applicant shall also submit either:
  - 1) Certification of active practice in another jurisdiction. Such certification shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the licensee was authorized to practice during the term of said active practice; or
  - 2) An affidavit attesting to military service as provided in Section 60(d) of the Act; or
  - 3) Proof of passage of the National Counselor Examination (NCE) or the Certified Rehabilitation Counselor Examination during the period the license was lapsed or on inactive status.

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- c) When the accuracy of any submitted documentation or the relevance or sufficiency of the coursework or experience is questioned by the ~~Division~~Department because of a lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking restoration of a license shall be required to:
- 1) Provide such information as may be necessary; and/or
  - 2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information or clear up any discrepancies or conflicts in information. Upon recommendation of the Board and approval by the ~~Division~~Department, an applicant shall have the license restored.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

## SUBPART B: LICENSED CLINICAL PROFESSIONAL COUNSELOR

**Section 1375.120 Application for Examination/Permanent Licensure as a Clinical Professional Counselor**

- a) Each applicant seeking original licensure under Section 35 of the Act shall file an application with the Division, on forms provided by the Division, ~~at least 90 days prior to an examination date~~. The application shall include:
- 1) ~~The~~For individuals who graduated or who were enrolled in a program prior to January 1, 1999 (these individuals have until January 1, 2003 to complete the educational requirements set forth in Section 1375.140(a); otherwise, the applicant will be required to meet the educational requirements set forth in Section ~~1375.145(a)~~1375.140(b):
  - A) ~~Either: i)~~ Certification of education from a master's degree program or doctoral degree in counseling, rehabilitation counseling or psychology from a college, university or school that is a regionally accredited institution of higher education and recognized by the U.S. Department of Education~~recognized by the educational governing authority in the jurisdiction in which it is located~~, or certification of education and an official transcript from a similar master's degree or doctoral degree program as defined in Section ~~1375.145(a)~~1375.140(a) ~~of this Part~~. ~~Individuals who have~~

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~~completed experience prior to January 1, 1999 may complete the equivalent of 2 units of acceptable experience (2 years full-time satisfactory supervised employment working as a counselor in a professional capacity under the direction of a qualified supervisor as defined in subsection (a)(1)(B) or 4 years working as a counselor in a professional capacity independent of the direction of a qualified supervisor subsequent to the degree or a combination of supervised experience and independent experience). All experience obtained beginning January 1, 1999 shall meet the experience requirements set forth in Section 1375.130.~~

ii) ~~Certification of education or an official transcript from a doctoral degree program in counseling, rehabilitation counseling, or psychology from a college, university or school recognized by the educational governing authority in the jurisdiction in which it is located or similar degree program as defined in Section 1375.140(a) of this Part. Individuals who have completed experience prior to January 1, 1999 may complete the equivalent of 2 units of acceptable experience (2 years of full-time satisfactory supervised experience working as a counselor in a professional capacity under the direction of a qualified supervisor or 4 years working as a counselor in a professional capacity independent of the direction of a qualified supervisor, as defined in subsection (a)(1)(B) or a combination of supervised experience and independent experience). All experience obtained beginning January 1, 1999 shall meet the experience requirements set forth in Section 1375.130.~~

B) ~~Experience earned prior to January 1, 1999 shall be documented as follows:~~

i) ~~Certification of experience signed by the applicant's supervisor. A qualified supervisor for purposes of this subsection (a)(1)(B)(i) is defined as any person who is a master's level or doctoral level counselor (such as, but not limited to, registered art therapist, licensed or registered marriage and family therapist, school counselor, school~~

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- ~~social worker, school psychologist, certified rehabilitation counselor at the master's level, pastoral counselor), a licensed clinical professional counselor, certified social worker or licensed clinical social worker, licensed/registered clinical psychologist, or psychiatrist as defined in Section 1-121 of the Mental Health and Developmental Disabilities Code; or~~
- ii) ~~Three affidavits from the applicant's colleagues, consultants and supervisors who are familiar with the applicant's work.~~
- B) One year of experience shall be a maximum of 1680 clock hours obtained in not less than 48 weeks. No more than 1680 clock hours may be counted toward one year of experience. Part time experience shall be counted toward the experience requirement.
- 2) ~~For individuals who graduated on or after January 1, 1999:~~
- A) ~~Certification of education or an official transcript from a master's degree program in counseling, rehabilitation counseling, or psychology from a regionally accredited college, school or university or similar degree program as defined in Section 1375.140(b) of this Part and completion of the equivalent of 2 years full-time satisfactory supervised employment or experience working as a counselor in a professional capacity under the direction of a qualified supervisor, subsequent to the degree, as defined in Section 1375.130 of this Part; or~~
- B) ~~Certification of education or an official transcript from a doctoral degree program in counseling, rehabilitation counseling, or psychology from a regionally accredited college, school or university or similar degree program as defined in Section 1375.140(b) of this Part and completion of the equivalent of 2 years of full-time satisfactory supervised experience working as a counselor in a professional capacity under the direction of a qualified supervisor, as defined in Section 10 of the Act, at least one year of which is subsequent to the degree.~~
- 3) ~~A complete work history since receipt of the first qualifying degree~~

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~~(master's or doctoral degree).~~

- 4) The fee required in Section 1375.205.
- 3)5) Certification of licensure, on forms provided by the Division, from the state or territory of the United States in which an applicant was originally licensed and the state in which the applicant predominantly practices and is currently licensed, if applicable, stating:
- A) The time during which the applicant was licensed in that jurisdiction, including the date of the original issuance in that jurisdiction;
  - B) A description of the examination in that jurisdiction; and
  - C) Whether the file on the applicant contains any record of disciplinary actions taken or pending.

b) Any individual who applies for a clinical professional counselor license after January 1, 2008 shall meet the educational requirements set forth in Section 1375.145(a).

1) Individuals applying for licensure as a clinical professional counselor may submit one of the following certifications (based on examination), in lieu of the documents required in subsection (a)(1):

A) Commission on Rehabilitation Counselor Certification (CRC);

B) Certified Clinical Mental Health Counselors Certification (CCMHC);

2) An applicant submitting one of the certifications listed in this subsection (b) will not be required to take and pass an additional examination administered by the Division. The Division, upon recommendation of the Professional Counselor Licensing and Disciplinary Board (Board), has determined that the education and examination requirements are equivalent to the requirements for licensure as a clinical professional counselor. The Division, upon recommendation of the Board, has determined that individuals who received their CRC certification after

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~~January 1992 have been determined to meet the education and examination requirements. Individuals who received a CRC certificate before 1992 will be required to submit an official transcript pursuant to Section 1375.145 in order to evaluate educational requirements. All applicants holding a current CRC certificate shall submit proof of experience. The Division, upon recommendation of the Board, has determined that individuals who hold the certification of a Certified Clinical Mental Health Counselor (CCMHC) based on examination meet the education, experience and examination requirements for licensure as a Clinical Professional Counselor.~~

- e) ~~The Division, upon recommendation of the Board, has determined that the individuals who hold a certification from the following groups meet the education requirements to be eligible to sit for the examination:~~
- ~~1) Clinical Member of the American Association for Marriage and Family Therapy (AAMFT);~~
  - ~~2) Fellow or Diplomate of the American Association of Pastoral Counselors (AAPC);~~
  - ~~3) Type 73 certificate issued by the Illinois State Board of Education as a School Counselor, if the holder of the certificate has graduated from a CACREP school counseling program or meets the educational standards set forth in Section 1375.50, Clinical Social Worker or School Psychologist.~~

~~An applicant shall submit a current certification from one of the above entities. The applicant shall submit certification of education and proof of experience and pass the examination set forth in Section 1375.150.~~

- d) ~~The Division, upon recommendation of the Board, has determined that individuals who received their Certified Rehabilitation Counselor (CRC) certification after January 1992 have been determined to meet the education and examination requirements. Individuals who received a CRC certificate before 1992 will be required to submit a transcript pursuant to Section 1375.150 in order to evaluate educational requirements. All applicants holding a current CRC certificate shall submit proof of experience.~~

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- ~~c)e~~ An applicant may begin gaining the required experience upon completion of the degree requirements. Verification of the date of completion of the degree, when different from the date of graduation, shall be certified to the Division by the applicant's educational institution.
- ~~d)f~~ When the accuracy of any submitted documentation or the relevance or sufficiency of the coursework or experience is questioned by the Division or the Board because of lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking licensure shall be requested to:
- 1) Provide such information as may be necessary; and/or
  - 2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information or clear up any discrepancies or conflicts in information.
- ~~e)g~~ If an applicant has taken and passed the examinations in accordance with Section 1375.150, the applicant shall file an application in accordance with subsection (a) and shall have the examination scores submitted to the Division directly from the testing entity or from the state of original licensure.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.130 Professional Experience for Licensure as a Clinical Professional  
Counselor ~~Beginning January 1, 1999~~**

~~Professional Beginning January 1, 1999 professional~~ counseling experience shall be obtained as set forth in this Section below:

- a) A person holding a master's degree in counseling, rehabilitation counseling, psychology or similar degree program shall have completed the equivalent of 2 years of full-time satisfactory supervised experience working as a counselor in a professional capacity under the direction of a qualified supervisor subsequent to the degree.
- b) A person holding a doctorate in counseling, rehabilitation counseling, psychology or similar degree program shall have completed the equivalent of 2 years of full-time satisfactory supervised experience working as a counselor in a professional

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capacity under the direction of a qualified supervisor at least one year of which is subsequent to the degree. Internships may count toward professional experience.

- c) A qualified supervisor means any person who is a licensed clinical professional counselor, licensed clinical social worker, licensed clinical psychologist, or psychiatrist as defined in Section 1-121 of the Mental Health and Developmental Disabilities Code. If supervision took place outside Illinois, the supervisor shall be a master's level or doctoral level counselor engaged in clinical professional counseling clinical social work, clinical psychology or psychiatry. The supervisor shall hold an active license if the jurisdiction in which the supervisor practices requires licensure.
- d) One year of experience shall be a maximum of 1680 clock hours obtained in not less than 4852 weeks, including 960 clock hours of direct face to face service to clients. Part time experience shall be counted toward the experience requirement.
- e) For purposes of this Section, supervised experience shall be experience obtained under a qualified supervisor as defined in Section 10 of the Act and entail the provision of professional counseling and mental health services defined in Section 10 of the Act.
  - 1) The supervisor shall have met with the applicant at least one hour each week. The supervision means the review of counseling and case management.
  - 2) The experience shall have been evaluated by the supervisor as satisfactory or better.
- f) Live faceFace to face supervision does not include mail, email, telefax, or phone or other such electronic devices.
- g) Acceptable modes for supervision of direct client contact are as follows:
  - 1) Individual supervision: the supervisory session is conducted by an approved supervisor with one or two counselors present.
  - 2) Group supervision: the supervisory session is conducted by an approved supervisor with no more than 5 counselors present.

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- h) The counseling activities must be performed pursuant to the supervisor's order, control, oversight, guidance and full professional responsibility.
- i) A qualified supervisor may be provided at the applicant's place of work or may be hired by the applicant to provide supervision.
- j) The following activities are not acceptable clinical supervision:
  - 1) Peer supervision.
  - 2) Administrative supervision. For example, clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.
  - 3) A primarily didactic process wherein techniques or procedures are taught in a classroom, workshop or seminar.
  - 4) Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.
- k) An applicant may begin gaining the required experience upon completion of the degree requirements. Verification of the date of completion of the degree, when different from the date of graduation, shall be certified to the Division by the applicant's educational institution.
- l) Professional experience may be gained through volunteering when the volunteer holds a licensed professional counselor license.
- m) When providing professional counseling services as set forth in Section 10 of the Act (in the independent practice of clinical professional counseling work), a licensed professional counselor shall always operate and represent himself/herself as an employee of the independent practice and may not work as an independent contractor as defined by Internal Revenue Service regulations.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.140 Approved Clinical Professional Counseling Programs (Repealed)**

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- a) ~~On or before December 31, 1998, the Division, upon recommendation of the Board, shall approve similar degree programs that meet the following requirements:~~
- 1) ~~Master's degrees shall be from a college, university or school recognized by the educational governing authority in the jurisdiction in which it is located. Doctoral degrees shall be accredited by an accrediting agency recognized by the U.S. Department of Education.~~
  - 2) ~~The program shall be 2 academic years and shall require an individual to complete a minimum of 30 semester hours or equivalent hours in any of the following 10 core areas:~~
    - A) ~~Human Growth and Development and Maladaptive Behavior~~
    - B) ~~Counseling Theory~~
    - C) ~~Counseling Techniques~~
    - D) ~~Group Dynamics, Processing and Counseling~~
    - E) ~~Appraisal of Individuals~~
    - F) ~~Research and Evaluation~~
    - G) ~~Professional, Legal and Ethical Responsibilities relating to professional counseling, especially as related to Illinois law~~
    - H) ~~Social and Cultural Foundations~~
    - I) ~~Lifestyle and Career Development~~
    - J) ~~Practicum~~
- b) ~~Beginning January 1, 1999 the Division shall, upon the recommendation of the Professional Counselor Examining and Disciplinary Board, approve counseling, rehabilitation counseling, psychology or similar degree programs at the master's or doctoral level if the program meets the following requirements:~~

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- 1) ~~The institution is a regionally accredited institution of higher education. Doctoral degrees shall be accredited by an accrediting agency recognized by the U.S. Department of Education.~~
- 2) ~~The programs, wherever they may be administratively housed, must be clearly identified and labeled as offering counseling, rehabilitation counseling or psychology programs. Such a program must specify in institutional catalogues and brochures its intent to educate and train counselors.~~
- 3) ~~The program is an organizational entity within the institution.~~
- 4) ~~The program has an integrated, organized sequence of study.~~
- 5) ~~The program must be 2 academic years in length and require an individual to complete a minimum of 48 semester hours or equivalent quarter hours with a minimum of one course (beginning January 1, 2008, "course" is defined as 3 semester hours or equivalent) in each of the following areas described in more detail in Appendix A of this Part:~~
  - A) ~~Human Growth and Development~~
  - B) ~~Counseling Theory~~
  - C) ~~Counseling Techniques~~
  - D) ~~Group Dynamics, Processing and Counseling~~
  - E) ~~Appraisal of Individuals~~
  - F) ~~Research and Evaluation~~
  - G) ~~Professional, Legal and Ethical Responsibilities relating to professional counseling, especially as related to Illinois law~~
  - H) ~~Social and Cultural Foundations~~
  - I) ~~Lifestyle and Career Development~~

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- J) ~~Practicum/Internship~~
- K) ~~Psychopathology and Maladaptive Behavior~~
- L) ~~Substance Abuse~~
- M) ~~Family Dynamics.~~
- 6) ~~The program has faculty responsible for the program and has a sufficient number of full-time instructors to make certain that the educational obligations to the student are fulfilled. The faculty must have degrees in their areas of teaching from professional colleges and institutions.~~
- 7) ~~The program has an identifiable body of students who are matriculated in that program for a degree.~~
- 8) ~~The program has a one-year residence. Residence requires interaction with faculty and other matriculated students. One year's residence is defined as 24 semester hours taken on a full-time or part-time basis at the institution accumulated within the time frame and course of study of the program.~~
- e) ~~Reevaluation of an Approved Program~~
  - 1) ~~The Division may reevaluate any approved program at any time if it has reason to believe that the program has failed to continue to satisfy the minimum requirements of this Section or that its decision was based upon false, deceptive or incomplete information.~~
  - 2) ~~A program whose approval is being reevaluated by the Committee shall be given at least 15 days written notice prior to any recommendation by the Board and may either submit written comments or request a hearing before the Board.~~
- d) ~~For the purposes of this Section, course shall be defined as an integrated, organized course of study that encompasses a minimum of one school semester or equivalent hours. No student designed courses, independent study courses, workshops or correspondence courses may be used to satisfy the core courses.~~

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- e) ~~The Division, upon recommendation of the Board, has determined that all master's degree and doctoral programs in professional counseling that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Council on Rehabilitation Education (CORE) and doctoral programs in psychology approved by the American Psychological Association and the Council for the National Registry of Health Service Providers are approved programs.~~
- f) ~~Individual Program Requirements~~
- 1) ~~Individuals applying for licensure as a clinical professional counselor who have not graduated from a master's or doctoral program approved by the Division shall submit their transcripts and program materials to the Division for evaluation by the Board to determine if they meet the requirements of this Section.~~
  - 2) ~~Individuals applying for licensure above who are deficient in any of the content areas set forth in subsection (b)(5) of this Section may complete any deficiencies in an approved counseling, rehabilitation counseling or psychology program. The applicant will be required to submit proof to the Division that he or she has passed such a course and/or the experience. Proof shall include, but not be limited to, curriculum, practicum, and program materials, internship handbook and course materials.~~
  - 3) ~~Individuals who are admitted to a degree program prior to January 1, 1999 have until January 1, 2003 to meet the educational requirements set forth in subsection (a) of this Section. After that date the applicant will be required to meet the curriculum requirements set forth in subsection (b) of this Section.~~

(Source: Repealed at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.145 Professional Education for Clinical Professional Counseling Programs**

- a) The educational requirements are as follows:
- 1) Master's degrees shall be from a college, university or school that is a regionally accredited institution of higher education and recognized by the U.S. Department of Education;

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- 2) The programs, wherever they may be administratively housed, must be clearly identified and labeled as offering counseling, rehabilitation counseling or psychology programs. Such a program must specify in institutional catalogues and brochures its intent to educate and train counselors;
- 3) The program is an organizational entity within the institution;
- 4) The program has an integrated, organized sequence of study;
- 5) The program must be at least 2 academic years in length and require an individual to graduate from a program with a minimum of 48 semester hours or 72 quarter hours with a minimum of one course ("course" is defined as 3 semester hours or equivalent) in each of the areas listed in this subsection (a)(5). The 13 areas are the same as those listed for the licensed professional counselor. "A minimum of one course" is defined to mean that the objectives and content of a course need to meet the requirements for one content area and cannot be used to meet the objectives and content requirements of another content area. (See Appendix A (Course Descriptions) for a definition of the subject content for each core area with examples of course titles that relate to each of the core content areas.) Students who started their educational program after January 1, 1999 and graduated before January 1, 2008 who make application for the Licensed Clinical Professional Counselor after January 1, 2008 must meet the hour requirements for each core areas established by their educational program at the time they started their graduate studies. In some cases, this may not be 3 semester hours or equivalent for each core area. All students, however, graduating after January 1, 2008 must meet the "3 semester hour or equivalent" requirement.
  - A) Human Growth and Development
  - B) Counseling Theory
  - C) Counseling Techniques
  - D) Group Dynamics, Processing and Counseling

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- E) Appraisal of Individuals
  - F) Research and Evaluation
  - G) Professional, Legal and Ethical Responsibilities Relating to Professional Counseling, Including Illinois Law
  - H) Social and Cultural Foundations
  - I) Lifestyle and Career Development
  - J) Practicum/Internship
  - K) Psychopathology and Maladaptive Behavior
  - L) Substance Abuse
  - M) Family Dynamics;
- 6) The program has faculty responsible for the program and has a sufficient number of full-time instructors to make certain that the educational obligations to the student are fulfilled. The faculty must have degrees in their areas of teaching from professional colleges and institutions;
  - 7) The program has an identifiable body of students who are matriculated in that program for a degree;
  - 8) The program has a one year residence. Residence requires interaction with faculty and other matriculated students. One year's residence is defined as 24 semester hours taken on a full-time or part-time basis at the institution accumulated within the time frame and course of study of the program.
- b) For the purposes of this Section, course shall be defined as an integrated, organized course of study that encompasses a minimum of one school semester or equivalent hours. No student designed courses, independent study courses, workshops or correspondence courses may be used to satisfy the core courses.
  - c) The Division, upon recommendations of the Board, has determined that all

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master's degree and doctoral programs in professional counseling or rehabilitation counseling that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Council on Rehabilitation Education (CORE) and doctoral programs in psychology approved by the American Psychological Association and the Council for the National Registry of Health Service Providers are approved programs.

d) Individual Program Requirements

1) Individuals applying for licensure as a clinical professional counselor who have not graduated from a program listed in subsection (c) shall submit their transcripts and program materials to the Division for evaluation by the Board to determine if they meet the requirements of this Section.

2) Individuals applying for licensure who are deficient in any of the content areas set forth in subsection (a)(6) may complete any content area deficiencies in a graduate counseling, rehabilitation counseling, or psychology program. No student designed courses, independent study courses, workshops or correspondence courses may be used to satisfy the core courses. The applicant will be required to submit proof to the Division that he or she has passed such a course. Proof shall include, but not be limited to, curriculum, practicum and program materials, internship handbook and course materials.

e) After January 1, 2008, all applicants will be required to meet the curriculum requirements set forth in this Section.

(Source: Added at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.150 Examination – Clinical Professional Counselor**

a) The examination for licensure as a clinical professional counselor shall be the National ~~Counselor Counseling~~ Examination (NCE) of the National Board for ~~Certified Clinical~~ Counselors (NBCC) and the National Clinical Mental Health Counseling Examination (NCMHCE) or the Examination of Clinical Counselor Practice (ECCP).

b) The passing score on the examination shall be the passing score established by the testing entity.

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- c) The ~~Division~~**Department** also shall accept passage of the Certified Rehabilitation Counselor Examination of the Commission on Rehabilitation Counselor Certification (CRCC).

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.160 Endorsement – Clinical Professional Counselor**

- a) Each applicant seeking licensure as a clinical professional counselor under Section 70 of the Act shall file an application with the Division on forms provided by the Division. The application shall include:

- 1) ~~The applicant will be required to meet the educational requirements set forth in Section 1375.145. For individuals who graduated prior to January 1, 1999:~~
- ~~A) Certification of education from a master's degree in counseling, rehabilitation counseling or psychology from a college, university or school recognized by the educational governing authority in the jurisdiction in which it is located, or certification of education and an official transcript from a similar master's degree program as defined in Section 1375.140 of this Part and completion of the equivalent of 2 units of acceptable experience (2 years full-time satisfactory supervised employment working as a counselor in a professional capacity under the direction of a qualified supervisor or 4 years working as a counselor in a professional capacity independent of the direction of a qualified supervisor, subsequent to the degree, as defined in Section 1375.120(a)(1)(B)(i) of this Part) or a combination of the supervised experience and independent experience. Experience earned on or after January 1, 1999 shall meet the requirements set forth in Section 1375.130; or~~
  - ~~B) Certification of education and an official transcript from a doctoral degree program in counseling, rehabilitation counseling, psychology or similar degree program as defined in Section 1375.140 of this Part and completion of the equivalent of 2 units of acceptable experience (2 years of full-time satisfactory supervised experience working as a counselor in a professional capacity under~~

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~~the direction of a qualified supervisor or 4 years working as a counselor in a professional capacity independent of the direction of a qualified supervisor, as defined in Section 1375.120(a)(1)(B)(i) or a combination of the supervised experience and independent experience. Experience earned on or after January 1, 1999 shall meet the requirements set forth in Section 1375.130.~~

2) ~~Applicants who graduated on or after January 1, 1999:~~

- A) Certification of education and an official transcript from a master's degree program in counseling, rehabilitation counseling, or psychology from a college, university or school that is a regionally accredited institution of higher education and is recognized by the U.S. Department of Education~~regionally accredited by the educational governing authority in the jurisdiction in which it is located~~ or similar degree program as defined in Section ~~1375.145~~1375.140 of this Part and completion of the equivalent of 2 years full-time satisfactory supervised employment or experience working as a counselor in a professional capacity under the direction of a qualified supervisor, subsequent to the degree, as defined in Section 1375.130 ~~of this Part~~; or
- B) Certification of education and an official transcript from a doctoral degree program in counseling, rehabilitation counseling, or psychology from a college, university or school that is a regionally accredited institution of higher education and is recognized by the U.S. Department of Education~~regionally accredited by the educational governing authority in the jurisdiction in which it is located~~ or similar degree program as defined in Section ~~1375.145~~1375.140 of this Part and completion of the equivalent of 2 years of full-time satisfactory supervised experience working as a counselor in a professional capacity under the direction of a qualified supervisor, as defined in Section 10 of the Act, at least one year of which is subsequent to the degree.

3) ~~Beginning January 1, 2005:~~

- A) ~~Certification of education and an official transcript from a master's or doctoral degree program in counseling, psychology,~~

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- ~~rehabilitation counseling or similar degree program approved in accordance with Section 1375.140(b) of this Part; or~~
- ~~B) Certification of education and an official transcript from a baccalaureate program in human services or similar degree program approved by the Division in accordance with Section 1375.140(b) of this Part and documentation of completion of 5 years of supervised professional experience in accordance with Section 1375.130 of this Part.~~
- ~~4) A complete work history since receipt of the master's or doctorate degree.~~
- ~~2)5) Successful completion of the examinations in accordance with Section 1375.150 of this Part.~~
- ~~3)6) The required fee set forth in Section 1375.205.~~
- ~~4)7) Certification of licensure, on forms provided by the Division, from the state or territory of the United States in which an applicant was originally licensed and the state in which the applicant predominantly practices and is currently licensed, if applicable, stating:~~
- ~~A) The time during which the applicant was licensed in that jurisdiction, including the date of the original issuance in that jurisdiction;~~
- ~~B) A description of the examination in that jurisdiction; and~~
- ~~C) Whether the file on the applicant contains any record of disciplinary actions taken or pending.~~
- b) The Division, upon recommendation of the Professional Counselor Licensing and Disciplinary Board (the Board), shall issue a license if a review of the application indicates that the applicant meets all the requirements of this Part and the Act.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.170 Restoration – Clinical Professional Counselor**

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- a) Any clinical professional counselor whose license has expired or has been placed on inactive status for 5 years or less may have the license restored by paying the fees required by Section 1375.205 and submitting proof of having met the continuing education requirements pursuant to Section 1375.220. Continuing education must be completed during the 24 months preceding application for restoration.
- b) Any person seeking restoration of a license that has been expired or placed on inactive status for more than 5 years shall file an application, on forms supplied by the ~~Division~~Department, together with the fee required by Section 1375.205 and submitting proof of having met the continuing education requirements pursuant to Section 1375.220. Continuing education must be completed during the 24 months preceding application for restoration. The applicant shall also submit either:
  - 1) Certification of active practice in another jurisdiction. Such certification shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the licensee was authorized to practice during the term of said active practice; or
  - 2) An affidavit attesting to military service as provided in Section 60(d) of the Act; or
  - 3) Proof of passage of the Certified Rehabilitation Counselor (CRC) examination or the Certified Clinical Mental Health Counselor (CCMHC) examination during the period the license was lapsed or on inactive status.
- c) When the accuracy of any submitted documentation or the relevance or sufficiency of the coursework or experience is questioned by the ~~Division~~Department because of a lack of information, discrepancies or conflicts in information given or a need for clarification, the applicant seeking restoration of a license shall be required to:
  - 1) Provide such information as may be necessary; and/or
  - 2) Appear for an interview before the Board to explain such relevance or sufficiency, clarify information or clear up any discrepancies or conflicts in information. Upon recommendation of the Board and approval by the ~~Division~~Department, an applicant shall have the license restored.

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(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

## SUBPART C: GENERAL

**Section 1375.200 Renewals**

- a) Every license issued under the Act shall expire on March 31 of odd numbered years. The holder of a license may renew ~~the~~<sup>such</sup> license ~~during the month~~ preceding the expiration date at a time determined by the Division by paying the fee set forth in Section 1375.205 and completing 30 hours of continuing education in accordance with Section 1375.220.
- b) It is the responsibility of each licensee to notify the ~~Division~~<sup>Department</sup> of any change of address. Failure to receive a renewal form from the ~~Division~~<sup>Department</sup> shall not constitute an excuse for failure to pay the renewal fee or to renew one's license.
- c) Practicing or offering to practice on a license that has expired or is in inactive status shall be considered unlicensed activity and shall be grounds for discipline pursuant to Section 80 of the Act.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.205 Fees**

The following fees shall be paid to the Department for the administration of the Act and are not refundable:

- a) Application Fees
  - 1) The fee for application for a license as a professional counselor or a clinical professional counselor is \$150.
  - 2) The fee for application as a continuing education sponsor is \$500. State colleges, State universities, and State agencies are exempt from payment of this fee.
- b) Renewal Fees

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- 1) The fee for the renewal of a license as a professional counselor or a clinical professional counselor shall be calculated at the rate of \$60 per year.
  - 2) The fee for renewal as a continuing education sponsor is \$250 for the renewal period.
- c) General Fees
- 1) The fee for the restoration of a license other than from inactive status is ~~\$50~~\$20 plus payment of all lapsed renewal fees, but not to exceed \$300.
  - 2) The fee for the issuance of a duplicate license, for the issuance of a replacement license for a license that has been lost or destroyed or for the issuance of a license with a change of name or address, other than during the renewal period, is \$20. No fee is required for name and address changes on ~~Division~~Department records when no duplicate license is issued.
  - 3) The fee for a certification of a licensee's record for any purpose is \$20.
  - 4) The fee to have the scoring of an examination authorized by the ~~Division~~Department reviewed and verified is \$20 plus any fees charged by the applicable testing service.
  - 5) The fee for a wall certificate showing licensure shall be the actual cost of producing the certificate.
  - 6) The fee for a roster of persons licensed as professional counselors or clinical professional counselors in this State shall be the actual cost of producing the roster.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.210 Inactive Status**

- a) Licensed professional counselors and clinical professional counselors who notify the ~~Division~~Department, on forms provided by the ~~Division~~Department, may place their licenses on inactive status and shall be excused from paying renewal

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fees until they notify the ~~Division~~Department in writing of the intention to resume active practice.

- b) Any licensed professional counselor and clinical professional counselor seeking restoration from inactive status shall do so in accordance with ~~Section 1275.80 or 1275.170 of~~ this Part.
- c) No professional counselor or clinical professional counselor whose license is on inactive status shall use the title "licensed professional counselor" or "licensed clinical professional counselor". Any person violating this subsection shall be considered to be practicing without a license and shall be subject to the disciplinary provisions of the Act.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.220 Continuing Education**

- a) Continuing Education Hours Requirements
  - 1) ~~In Beginning with the March 31, 2001 renewal and every renewal thereafter, in~~ order to renew a license, a licensee shall be required to complete 30 hours of continuing education. ~~All Beginning with the March 31, 2007 renewal, all~~ clinical professional counselors are required to complete 18 hours in clinical supervision training of the 30 continuing education hours required. This is a one time (lifetime) requirement. All supervision training successfully completed subsequent to September 1, 2003 can be applied to the 18 hours of clinical supervision continuing education required.
  - 2) A prerenewal period is the 24 months preceding March 31 of each odd-numbered year.
  - 3) CE requirements shall be the same for licensed professional counselors and licensed clinical professional counselors.
  - 4) One CE hour shall equal one clock hour of attendance. After completion of the initial CE hour, credit may be given in one-half hour increments.
  - 5) A renewal applicant shall not be required to comply with CE requirements

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for the first renewal of an Illinois license.

- 6) Professional counselors or clinical professional counselors licensed in Illinois but residing and practicing in other states or jurisdictions shall comply with the CE requirements set forth in this Section.
  - 7) Continuing education credit hours used to satisfy the CE requirements of another jurisdiction may be applied to fulfill the CE requirements of the State of Illinois.
- b) Approved Continuing Education (CE)
- 1) CE hours shall be earned by verified attendance (e.g., certificate of attendance or certificate of completion) at or participation in a program or course (program) that is offered or sponsored by an approved continuing education sponsor who meets the requirements set forth in subsection (c), except for those activities provided in subsections (b)(2), (3) and (4).
  - 2) A maximum of 15 CE credits per renewal period may be earned for successful completion of a correspondence course (e.g., by mail, computer, etc.) that is offered by an approved sponsor who meets the requirements set forth in subsection (c). Each correspondence course shall include an examination.
  - 3) CE credit may be earned through postgraduate training programs (e.g., extern, residency or fellowship programs) or completion of professional counseling related courses that are a part of the curriculum of a college, university or graduate school. Courses that are part of the curriculum of a university, college or other educational institution shall be allotted CE credit at the rate of 15 CE hours for each semester hour or 10 CE hours for each quarter hour of school credit awarded.
  - 4) CE credit may be earned for verified teaching in the field of counseling in an accredited college, university or graduate school and/or as an instructor of continuing education programs given by approved sponsors. Credit will be applied at the rate of 1.5 hours for every hour taught and only for the first presentation of the program (i.e., credit shall not be allowed for repetitious presentations of the same program). A maximum of 10 hours of CE credit may be obtained in this category per prerenewal period.

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- 5) CE credit may be earned for authoring papers, publications, dissertations or books and for preparing presentations and exhibits in the field of counseling. The preparation of each published paper, book chapter or professional presentation dealing with professional counseling or clinical professional counseling may be claimed as 5 hours of credit. A presentation must be before an audience of professional counselors. Five credit hours may be claimed for only the first time the information is published or presented.
  - 6) A maximum of 8 hours of CE credit may be earned per renewal period for clinical supervision received or provided on a regular basis with a set agenda. Clinical supervision~~Supervision~~ shall be documented with a letter from the supervisor indicating the start and end dates in which the supervision occurred, the site where supervision was provided, the number of hours of participation and the name and license number of the supervisor. The letter shall be signed by the supervisor and the supervisee.
  - 7) A maximum of 6 hours of CE credit may be earned per renewal period for leadership activities. Such activities include, but are not limited to, officer of a state or national counseling organization; editor of a professional counseling journal; member of a national counselor certification board; member of a national ethics disciplinary review committee; chair of a major counseling conference or convention; active member of a counseling committee producing a substantial written product. The leadership shall be documented in a letter of confirmation on the organization's letterhead and shall include the start and end dates of leadership, the name of the organization and the position held.
- c) Approved CE Sponsors and Programs
- 1) Sponsor, as used in this Section, shall mean:
    - A) National Board for Certified Counselors or its affiliates;
    - B) American Counseling Association or its affiliates;
    - C) Commission on Rehabilitation Counselor or its affiliates;

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- D) American Association for Marriage and Family Therapy or its affiliates;
  - E) Employee Assistance Professional Association (EAPA) and Employee Assistance Society of North America (EASNA) or its affiliates;
  - F) Social Work Continuing Education Sponsors approved by the Division in accordance with the rules for the administration of Clinical Social Work and Social Work Practice Act [225 ILCS 20], 68 Ill. Adm. Code 1470.95;
  - G) American Psychological Association or its affiliates; and
  - H) Any other accredited school, college or university, State agency, or any other person, firm, or association that has been approved and authorized by the Division pursuant to subsection (c)(2) of this Section to coordinate and present continuing education courses and programs.
- 2) An entity seeking approval as a CE sponsor pursuant to subsection (c)(1)(H) shall submit an application, on forms supplied by the Division, along with the fee set forth in Section 1375.205. (State agencies, State colleges and State universities in Illinois shall be exempt from paying this fee.) The application shall include:
- A) Certification:
    - i) That all programs offered by the sponsor for CE credit shall comply with the criteria in subsection (c)(3) and all other criteria in this Section;
    - ii) That the sponsor shall be responsible for verifying full-time continuous attendance at each program and provide a certificate of attendance as set forth in subsection (c)(9);
    - iii) That, upon request by the Division, the sponsor shall submit evidence (e.g., certificate of attendance or course material) as is necessary to establish compliance with this

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Section. Evidence shall be required when the Division has reason to believe that there is not full compliance with the statute and this Part and that this information is necessary to ensure compliance;

- B) A copy of a sample program with faculty, course materials and syllabi.
- 3) All programs shall:
- A) Contribute to the advancement, extension and enhancement of the professional skills and scientific knowledge of the licensee in the practice of professional counseling or clinical professional counseling;
  - B) Foster the enhancement of general or specialized counseling or clinical counseling practice and values;
  - C) Be developed and presented by persons with education and/or experience in the subject matter of the program;
  - D) Specify the course objectives, course content and teaching methods to be used; and
  - E) Specify the number of CE hours that may be applied to fulfilling the Illinois CE requirements for license renewal.
- 4) Each CE program shall provide a mechanism for evaluation of the program and instructor by the participants. The evaluation may be completed on-site immediately following the program presentation or an evaluation questionnaire may be distributed to participants to be completed and returned by mail. The sponsor and the instructor, together, shall review the evaluation outcome and revise subsequent programs accordingly.
- 5) An approved sponsor may subcontract with individuals and organizations to provide approved programs. All advertising, promotional materials, and certificates of attendance must identify the licensed sponsor and the sponsor's license number. The presenter of the program may also be

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identified, but should be identified as a presenter. When a licensed sponsor subcontracts with a presenter, the licensed sponsor retains all responsibility for monitoring attendance, providing certificates of attendance and ensuring the program meets all of the criteria established by the Act and this Part, including the maintenance of records.

- 6) All programs given by approved sponsors shall be open to all licensed professional counselors and licensed clinical professional counselors and not be limited to members of a single organization or group.
- 7) To maintain approval as a sponsor pursuant to subsection (c)(2), each shall submit to the Division by March 30 of each odd-numbered year a renewal application, the fee set forth in Section 1375.205 and a list of courses and programs offered within the last 24 months. The list shall include a brief description, location, date and time of each course given by the sponsor and by any subcontractor.
- 8) Certification of Attendance. It shall be the responsibility of a sponsor to provide each participant in a program with a certificate of attendance or participation. The sponsor's certificate of attendance shall contain:
  - A) The name, address and license number of the sponsor;
  - B) The name and address of the participant;
  - C) A brief statement of the subject matter;
  - D) The number of hours attended in each program;
  - E) The date and place of the program; and
  - F) The signature of the sponsor or person responsible for the CE program.
- 9) The sponsor shall maintain attendance records for not less than 5 years.
- 10) The sponsor shall be responsible for assuring that no renewal applicant shall receive CE credit for time not actually spent attending the program.

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- 11) Upon the failure of a sponsor to comply with any of the requirements of this Section, the Division, after notice to the sponsor and hearing before and recommendation by the Board (see 68 Ill. Adm. Code 1110), shall thereafter refuse to accept for CE credit attendance at or participation in any of that sponsor's CE programs until such time as the Division receives assurances of compliance with this Section.
  - 12) Notwithstanding any other provision of this Section, the Division or Board may evaluate any sponsor of any approved CE program at any time to ensure compliance with requirements of this Section.
- d) Certification of Compliance with CE Requirements
- 1) Each renewal applicant shall certify, on the renewal application, full compliance with the CE requirements set forth in subsections (a) and (b).
  - 2) The Division may require additional evidence demonstrating compliance with the CE requirements (e.g., certificate of attendance). This additional evidence shall be required in the context of the Division's random audit. It is the responsibility of each renewal applicant to retain or otherwise produce evidence of compliance.
  - 3) When there appears to be a lack of compliance with CE requirements, an applicant shall be notified in writing and may request an interview with the Board. At that time the Board may recommend that steps be taken to begin formal disciplinary proceedings as required by Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65].
- e) Continuing Education Earned in Other Jurisdictions
- 1) If a licensee has earned or is seeking CE hours offered in another jurisdiction not given by an approved sponsor for which the licensee will be claiming credit toward full compliance in Illinois, the applicant shall submit an individual program approval request form, along with a \$25 processing fee, prior to participation in the program or within 90 days after expiration of the license. The Board shall review and recommend approval or disapproval of the program using the criteria set forth in subsection (c)(3) ~~of this Section.~~

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- 2) If a licensee fails to submit an out of state CE approval form within the required time frame, late approval may be obtained by submitting the approval request form with the \$25 processing fee plus a \$50 per CE hour late fee not to exceed \$300. The Board shall review and recommend approval or disapproval of the program using the criteria set forth in subsection (c)(3) ~~of this Section~~.
- f) Restoration of Nonrenewed License. Upon satisfactory evidence of compliance with CE requirements, the Division shall restore the license upon payment of the required fee as provided in Section ~~1375.20513(4) and (5) of the Act~~.
- g) Waiver of CE Requirements
  - 1) Any renewal applicant seeking renewal of a license without having fully complied with these CE requirements shall file with the Division a renewal application along with the required fee set forth in Section ~~1375.20513(3) of the Act~~, a statement setting forth the facts concerning noncompliance and request for waiver of the CE requirements on the basis of these facts. A request for waiver shall be made prior to the renewal date. If the Division, upon the written recommendation of the Board, finds, from such affidavit or any other evidence submitted, that extreme hardship has been shown for granting a waiver, the Division shall waive enforcement of CE requirements for the renewal period for which the applicant has applied.
  - 2) Extreme hardship shall be determined on an individual basis by the Board and be defined as an inability to devote sufficient hours to fulfilling the CE requirements during the applicable prerenewal period because of:
    - A) Full-time service in the armed forces of the United States of America during a substantial part of the prerenewal period;
    - B) An incapacitating illness documented by a statement from a currently licensed physician;
    - C) A physical inability to travel to the sites of approved programs documented by a currently licensed physician; or
    - D) Any other similar extenuating circumstances.

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- 3) Any renewal applicant who, prior to the expiration date of the license, submits a request for a waiver, in whole or in part, pursuant to the provisions of this Section shall be deemed to be in good standing until the final decision on the application is made by the Division.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.225 Unprofessional Conduct**

The ~~Division~~**Department** may suspend or revoke a license, refuse to issue or renew a license or take other disciplinary action, based upon its finding of unethical, unauthorized, or unprofessional conduct within the meaning of Section 80 of the Act, which is interpreted to include, but is not limited to, the following acts or practices:

a) Counseling Relationships

- 1) Practicing, condoning, facilitating, ~~or~~ collaborating with or engaging in any form of discrimination based on age, culture, disability, ethnicity, race. The counselor shall act to prevent and eliminate discrimination against any person or group on the basis of race, color, sex, sexual orientation, age, religion/spiritually, gender, gender identity, sexual orientation, national origin, marital status/partnership, language preference, socioeconomic, political belief, mental or physical handicap, or any other preference or personal characteristic, condition or status, or any basis prescribed by law. Counselors shall not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.
- 2) Engaging in any action that violates or diminishes the civil or legal rights of clients.
- 3) Engaging in the sexual exploitation of clients, client's romantic partners, or client's family members, students or supervisees.
- 4) Engaging in or condoning sexual harassment, including, but not limited to, which is defined as deliberate or repeated comments, gestures or physical contacts of a sexual nature, that occurs in connection with professional activities or roles.

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- 5) Bringing personal or professional biases into the counseling relationship. Through an awareness of the impact of stereotyping and discrimination (i.e., biases based on age, disability, ethnicity, gender, religion, or sexual preference), counselors guard the individual rights and personal dignity of the client in the counseling relationship.
- 6) Engaging in any type of sexual or romantic intimacies with clients, client's romantic partners, or client's family members. Counselors shall not provide counseling services to persons with whom they have had a sexual relationship, including the person's romantic partners, or their family members.
- 7) Engaging in sexual intimacies with former clients, client's romantic partners, or client's family members prior to five~~two~~ years after termination of the counselor/client relationship.
- 8) Engaging in any nonprofessional relationships with clients, former clients, client's romantic partners, or client's family members should be avoided, except when the interaction is potentially beneficial to the client. All potentially beneficial relationships must be documented in case notes, and conducted with full client consent. When unintentional harm occurs to the client, or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy that harm.
- 9) Failing to offer all pertinent facts regarding services rendered to the client prior to administration of professional services. The purpose of informed consent is to insure a client's complete access to information pertaining to professional services. Examples include, but are not limited to, the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials and relevant experience; continuation of services upon the incapacitation or death of a counselor. Counselors must take steps to ensure that clients understand the implications of diagnosis, the intended use of assessments and reports, billing arrangements, fees for services, length of treatment and utilization of consultants. The client's signature indicating receipt of pertinent information is strongly encouraged.

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## b) Confidentiality

- 1) Failing to inform clients at the onset of the counseling relationship of the limits of confidentiality. These limitations include, but are not limited to: limitations mandated by the law, requirements to protect clients or identified others from serious and foreseeable harm, or the clear and immediate danger to oneself or others, when the counselor is a defendant in a civil, criminal or disciplinary action arising from the counseling.
- 2) Revealing facts, data or information relating to a client or examinee, except as allowed under Section 75 of the Act or under the Mental Health and Developmental Disabilities Confidentiality Act or any other federal or State laws pertaining to confidentiality.
- 3) Failing to take appropriate steps to protect the privacy of a client and avoid unnecessary disclosures of confidential information. The right to privacy belongs to clients and may be waived. A written waiver shall be signed by the client and the information revealed shall be in accordance with the terms of the waiver.

## c) Scope of Practice/Professional Responsibility

- 1) Performing, or pretending to be able to perform, professional services beyond one's scope of practice and one's competency, as defined by education, training, supervised experience, State and national professional credentials, and appropriate professional experience.
- 2) Abandoning or neglecting clients and/or failing to refer and/or make appropriate arrangements for the continuation of treatment, when necessary, during interruptions, such as vacations or illness, and following termination~~Failing to refer an individual with whom the counselor has a relationship.~~
- 3) Failing to use techniques/procedures/modalities that are grounded in professionally accepted theory and/or have an empirical or scientific foundation. Counselors who do not use these tools, must define the techniques/procedures as "unproven" or "developing" and explain the potential risk and ethical considerations of using the techniques/procedures and take steps to protect clients from possible

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~~harm~~inform clients of the use of all experimental methods of treatment; the safety precautions shall be adhered to by the counselor.

- 4) Failing to establish and maintain client records and case notes, including failing to inform clients of issues related to the difficulty of maintaining the confidentiality of electronically transmitted communication. Records must be maintained for at least 7 years. In the case of a minor, records must be maintained 7 years after the minor turns 18.
  - 5) Failing to inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/billing procedures. These technologies include but are not limited to computer hardware and software, telephone, the internet, online assessment instruments, and other communication devices.
  - 6) Advertising shall not be deceptive, misleading or false. Counselors should claim or imply only professional credentials possessed and are responsible for correcting any misrepresentations of their credentials by others. Professional credentials include highest relevant degrees, accreditation of graduate programs, national voluntary certifications, government-issued certifications or licenses, professional membership, or any other credential that might indicate to the public specialized knowledge or expertise in professional counseling.
  - 7)6) Submission of fraudulent claims for services to any person or entity including, but not limited to, health insurance companies or health service plans or third party payors.
  - 8)7) Knowingly offering or providing services to a client when the counselor's ability to practice is impaired. Failing to seek assistance for problems that reach the level of professional impairment, and, if necessary, limiting, suspending or terminating his or her professional responsibilities until such time it is determined that it is safe to resume work. Causes of impairment may include, but are not limited to, the abuse of mood altering chemicals and physical or mental problems; offering professional services when the counselor's personal problems or conflicts may harm a client or others.
- d) Supervision

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- 1) Permitting a ~~supervisee~~trainee or intern under his/her supervision or control to perform, or permitting the ~~supervisee~~trainee or intern to hold himself or herself out as competent to perform, professional services beyond the ~~supervisee's~~trainee's or intern's level of education, training and/or experience.
  - 2) Allowing a ~~supervisee~~trainee to violate the rights of clients, permitting a ~~supervisee~~trainee to violate confidentiality standards or client privacy, or failing to provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality, including who will have access to records of the counseling relationship and how these records will be used~~ensure that the client is informed that he/she is being treated by a trainee.~~
  - 3) Participating in any form of sexual or romantic contact with supervisees. ~~Nonprofessional~~Dual relationships with supervisees that might impair the supervisor's objectivity and professional ~~judgment~~judgement should be avoided and/or the supervisory relationship terminated.
- e) Evaluation, Assessment and Interpretation
- 1) ~~Failing to~~Different tests demand different levels of competence for ~~administration, scoring and interpretation.~~ Members must have the appropriate education and training for each specific assessmenttest and recognize the limits of their competence and perform only those functions for which they are prepared. In particular, ~~counselors~~members using ~~technology-assisted~~computer-based test interpretations must be trained in the construct~~concept~~ being measured and the specific instrument being used prior to using this ~~technology-based~~type of computer application.
  - 2) ~~F~~ Failing to inform prospective research participantsubjects or their authorized representative fully of potential serious after effects of the research or failing to remove the after effects as soon as the design of the research permits.
- f) ~~g~~ The ~~Division~~Department hereby incorporates by reference "The American Counseling Association Code of Ethics and Standards of Practice", April ~~2005~~1995, approved by the American Counseling Association, 5999 Stevenson

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Avenue, Alexandria, Virginia 22304, with no later amendments or editions.

- g) Licensed Professional Counselors and Licensed Clinical Professional Counselors are responsible for professional conduct consistent with every standard, in addition to the ones summarized in this Section, published in the 2005 American Counseling Association Code of Ethics.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

**Section 1375.230 Granting Variances**

- a) The Director of the Division of Professional Regulation (Director) with the authority delegated by the Secretary~~Department~~ may grant variances from this Part in individual cases when he or she~~he/she~~ finds that:
- 1) The provision from which the variance is granted is not statutorily mandated;
  - 2) No party will be injured by the granting of the variance; and
  - 3) The rule from which the variance is granted would, in the particular case, be unreasonable or unnecessarily burdensome.
- b) The Director shall notify the Board of the granting of asueh variance, and the reasons for granting the variancetherefor, at the next meeting of the Board.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

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**Section 1375.APPENDIX A Course Descriptions**

The following counselor education course content areas are defined and subject areas outlined; however, this is not an all inclusive list and many other courses may fall within each of the core content areas.

- a) Human Growth and Development: Courses in this area cover one or more of the various stages of the human growth cycle and include information about theories of development ~~or about various aspects of development~~ such as physical, personality-development, social-development, cognitive, moral and creative development, etc. ~~or learning theory. Also included are psychological, sociological, and physiological approaches.~~ Examples of acceptable courses include, but are not limited to, Human Growth and Development, Developmental Psychology, Child Psychology, Child Development, Adolescent Psychology, Adolescent Development, Personality Theory, Learning Theory, Counseling in the Life Span Development, Adult Development, Medical Aspects of Disability, Developmental Disabilities, Behavioral Analysis in Rehabilitation.
- b) Counseling Theory: Courses in this area cover the major theories of counseling and techniques of counseling and psychotherapy including, but not limited to, rational-emotive therapy, behavior therapy, client-centered counseling, psychodynamic theory, etc. Examples of acceptable courses include, but are not limited to, Counseling Methods, Theories of Counseling, Introduction to Psychotherapy, and overview courses in Behavior, Cognitive, Humanistic and Psychodynamic Theories, Methods of Psychotherapy. These courses should be general theory courses. ~~A;~~ a course devoted to one type of counseling/therapy would be considered a Counseling Technique ~~Techniques~~ core course.
- c) Counseling Techniques: Courses in this area cover the theoretical foundations and professional skill training enabling the counselor to that enable the helper to understand presenting problem, best practice recommendations, and effective intervention strategies ~~the client's problems more fully and accurately and to intervene effectively.~~ Examples of acceptable courses include, but are not limited to, Rational Emotive Therapy, Behavior Modification, Marital/Couples Family Counseling, Marital Counseling, Crisis Counseling, Counselor Interviewing Skills, Pre-Practicum in Rehabilitation Counseling, Introduction to Rehabilitation Counseling, Grief Therapy, Substance Abuse Counseling, Stress Management, etc.

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- d) Group Dynamics, Processing and Counseling: Courses in this area teach the theories, principles and techniques of ~~group~~ counseling ~~and group~~ psychotherapy ~~with groups of people~~. Examples of acceptable courses include, but are not limited to, Group Counseling, Group Counseling and Dynamics, Group Therapy, Group Dynamics, ~~Group Process~~, Theories of Group Practice, etc. Courses that use a group format with a focus on the professional development of the counselor is not considered a group course.
- e) Appraisal of Individuals: Courses in this area cover assessment of the various attributes of a person ~~through, including formal measures such as~~ standardized tests ~~as well as informal measures such as observations, interviews, rating scales~~. The course also includes an overview of statistical procedures relevant to test standardization and interpretation. Examples of acceptable courses include, but are not limited to, Individual Appraisal, ~~Individual Inventory~~, Group Testing, Standardized Testing, Individual Intelligence Testing, Personality Assessment, Introduction to Psychological ~~Measurements~~ Measurement, Tests and Measurements, ~~Measurement for Guidance~~, etc.
- f) Research and Evaluation: Courses in this area cover statistical principles, research design ~~principles~~, methods, techniques and tools used in performing ~~and interpreting~~ research in counseling. Examples of acceptable courses include, but are not limited to, Methods of Research, Statistics, Research Design, Research in Counseling, Research Techniques, etc.
- g) Professional, Legal and Ethical Responsibilities, ~~Especially as Related to Illinois Law~~: Courses in this area ~~cover~~ ~~introduce the student to the field of counseling,~~ ~~covering~~ such ~~topics~~ ~~areas~~ as professionalism in counseling, federal and State laws relevant to counselors, legal issues and responsibilities, and ethics with an emphasis on the Code of Ethics of the American Counseling Association. Examples of acceptable courses include, but are not limited to, Ethics and Legal Issues in Counseling, Ethics and Legal Issues in Psychology, Ethics and Legal Issues in Psychotherapy, Ethics and Legal Issues in Professional Counseling, Ethics and Legal Issues in Rehabilitation Counseling, etc.
- h) Social and Cultural Foundations: Courses in this area should include an overview of multicultural issues. The course should not focus on only one cultural group or counseling population. Courses in this area cover topics such as aging, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual

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~~orientation, marital status/partnership, language preference, and socioeconomic status; women's issues, urban and rural societies, population patterns, cultural mores, and differing life patterns. Culture and social class present significant considerations for counselors when the counseling relationship is different due to socialization acquired in distinct cultural, subcultural, racial-cultural or socioeconomic environments.~~ Examples of acceptable courses include, but are not limited to, Multicultural Counseling, Cultural Differences in Counseling, Cultural Differences in Psychology of Women, Counseling the Aged, Counseling with Special Populations, Social Psychology, Cultural Differences in Rehabilitation Counseling, (or Psychotherapy), Psychosocial Aspects of Disability, Somatopsychology of Disability, Psychological Aspects of Disability, etc.

- i) Lifestyle and Career Development: Courses in this area cover the lifelong processes and the influences ~~upon them~~ that lead to work values, occupational choices, ~~creation of a career path/patterns~~pattern, decision-making style, and integration of ~~roles~~, self- and career-identity ~~with~~and patterns of work adjustment. ~~The course is designed around the~~This area studies concepts ~~of about how~~ career development ~~unfolds~~. Examples of acceptable courses include, but are not limited to, ~~Career Guidance~~, Career Counseling, Career Development, ~~Career Information, Educational and Occupational Information~~, Theories of Vocational Choice, Theories of Vocational Counseling, ~~Work Adjustment and Placement~~, etc.
- j) Practicum: Provides practical experience in counseling for the purpose of developing both individual and group counseling skills ~~and for developing group counseling skills~~. This course should include a minimum of 100 clock hours on-site, with a minimum of 40 hours of direct client contact. These experiences allow students to perform ~~, on a limited basis,~~ some of the counseling activities that ~~an employed a regularly employed~~ Licensed Clinical Professional Counselor would be expected to perform. Supervision is required on an ongoing basis during the practicum. Practicum requirements ~~This~~ should not be confused with the internship requirements~~requirement~~.
- k) Internship: An internship should provide direct client experiences in assessment, experience in both individual counseling and group counseling work, as well as opportunities an opportunity for the student to become familiar with a variety of professional activities other than direct service (e.g., referral sources, case histories and progress notes, data management, etc.). ~~The internship.~~ It

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should provide an opportunity for a student to perform, ~~under supervision~~, a variety of activities that a Licensed Clinical Professional Counselor ~~clinical professional counselor~~ would be expected to perform. ~~The internship should include a~~ minimum of 600 clock hours with a minimum of 1 hour per week of ~~individual~~ supervision is required during the internship. Examples of acceptable courses include, but are not limited to, Internship – Community Counseling, Internship – Mental Health Counseling, Internship – Art Therapy, Internship – Pastoral Counseling, and Internship – Rehabilitation Counseling.

- l) ~~Counseling Education:—Courses in this area cover an understanding of all aspects of professional functioning including history, roles, organizational structures and credentialing. Examples of acceptable courses include, but are not limited to, The Counseling Profession, Professional Orientation. m) Counseling Supervision: Courses in this area cover the theory and practice of counselor supervision. Examples of acceptable courses include, but are not limited to, Principles and Practices of Supervision, Seminar in Supervision, Staff Development and Supervision, organization and administration of career counseling programs, administration of student personnel services. n) Family Dynamics:—Courses in this area cover family systems theory and its application, preventive approaches for working with families, specific problems that impede family function. Examples of acceptable courses include, but are not limited to, Introduction to Family Therapy, Societal Trends and Related Treatment Issues, Family Systems Theory, Family Dynamics. o) Psychopathology and Maladaptive Behavior: Courses in this area cover general principles of etiology, diagnosis, treatment, and prevention, and cultural factors of mental and emotional disorders. Emphasis is placed on and dysfunctional behavior, specific models and methods for assessing mental status assessment and, identification of abnormal, deviant or psychopathological behavior and the interpretation of findings in current diagnostic categories as organized in the DSM-IV-TR (or current edition). Examples of acceptable courses include, but are not limited to, Abnormal Psychology, Psychopathology, Diagnosis and Treatment Planning, Principles of Psychiatric Rehabilitation, Mental Health Rehabilitation Counseling, Psychosocial Aspects of Disability and Rehabilitation of the Mentally III.~~
- m)p) Substance Abuse: Courses in this area cover chemical, psychological and social ~~treatment~~ aspects of drug use, abuse and dependency, and effects on the family. Counseling skills are acquired in the areas of, treatment procedures, and diagnostic, assessment, diagnosis, and treatment intervention skills. Examples of acceptable courses include, but are not limited to, Substance Abuse Counseling,

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Psychology of Drug Addiction, Drugs and Alcohol Abuse. Psychopharmacology is not considered a course in substance abuse counseling, psychology of drug addition.

- n) Family Dynamics: Courses in this area cover family systems theory and its applications, prevention approaches for working with families, and specific problems that impede family function. Examples of acceptable courses include, but are not limited to, Family Therapy, Family Counseling, Family Systems Theory, and Family Dynamics.
- q) Counseling Administration: Courses in this area cover theories and models of organizational behavior and consultation that include planning and evaluation of community/higher education programs, theories; models and practice of leadership, organizational management, and program development; methods of and approaches to organizational change, decision making, and conflict resolution. Courses in this area cover, but are not limited to, Counseling Administration, Administrative Practice in Higher Education.

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

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**Section 1375.APPENDIX B Education, Experience and Examination History**

- a) Licensed Professional Counselor  
Through December 31, 1998:
- 1) Certification of education from a master's or doctoral degree program in counseling, psychology or rehabilitation counseling from a college, university or school recognized by the educational accrediting authority in the jurisdiction in which it is located, or certification of education and a transcript from a similar master's or doctoral degree program approved by the Divison~~Department~~ in accordance with Section 1375.50(a) of this Part; or
  - 2) Certification of a baccalaureate degree from a college, university or school recognized by the educational accrediting authority in the jurisdiction in which it is located and 5 years of full time satisfactory supervised experience as a professional counselor as defined in Section 1375.30(a)(1)(B).
- b) Licensed Clinical Professional Counselor  
Prior to January 1, 1999, the examination for licensure as a clinical professional counselor shall be the National Clinical Mental Health Counseling Examination (NCMHCE).

(Source: Amended at 35 Ill. Reg. 7586, effective May 13, 2011)

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- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3) Section Number: 140.1010                      Adopted Action:  
New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendment: May 1, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any 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: January 14, 2011; 35 Ill. Reg. 687
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version: New subsections (f) and (g) were added.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any other amendments pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
140.461	Amendment	November 29, 2010; 34 Ill. Reg. 17799
140.462	Amendment	October 29, 2010; 34 Ill. Reg. 16670
140.464	Amendment	October 29, 2010; 34 Ill. Reg. 16670
140.438	Amendment	August 6, 2010; 34 Ill. Reg. 10967

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- 15) Summary and Purpose of Amendment: This rulemaking allows the Department to mandate individuals to enroll in Managed Care Organizations (MCOs). The authority is not limited to any particular population or geographic area.
- 16) Information and questions regarding this adopted amendment shall be directed to:

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

217/782-1233

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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENT

## TITLE 89: SOCIAL SERVICES

## CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## SUBCHAPTER d: MEDICAL PROGRAMS

## PART 140

## MEDICAL PAYMENT

## SUBPART A: GENERAL PROVISIONS

## Section

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

## SUBPART B: MEDICAL PROVIDER PARTICIPATION

## Section

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

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

## SUBPART C: PROVIDER ASSESSMENTS

- Section
- 140.80 Hospital Provider Fund
- 140.82 Developmentally Disabled Care Provider Fund
- 140.84 Long Term Care Provider Fund
- 140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
- 140.95 Hospital Services Trust Fund
- 140.96 General Requirements (Recodified)

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

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- 140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services  
(Recodified)
- 140.398 Hearings (Recodified)

## SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

## Section

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

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

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

## SUBPART E: GROUP CARE

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

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140.520	Management of Recipient Funds – Local Office Responsibility
140.521	Room and Board Accounts
140.522	Reconciliation of Recipient Funds
140.523	Bed Reserves
140.524	Cessation of Payment Due to Loss of License
140.525	Quality Incentive Program (QUIP) Payment Levels
140.526	County Contribution to Medicaid Reimbursement
140.527	Quality Incentive Survey (Repealed)
140.528	Payment of Quality Incentive (Repealed)
140.529	Reviews (Repealed)
140.530	Basis of Payment for Long Term Care Services
140.531	General Service Costs
140.532	Health Care Costs
140.533	General Administration Costs
140.534	Ownership Costs
140.535	Costs for Interest, Taxes and Rent
140.536	Organization and Pre-Operating Costs
140.537	Payments to Related Organizations
140.538	Special Costs
140.539	Reimbursement for Basic Nursing Assistant, Developmental Disabilities Aide, Basic Child Care Aide and Habilitation Aide Training and Nursing Assistant Competency Evaluation
140.540	Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
140.541	Salaries Paid to Owners or Related Parties
140.542	Cost Reports – Filing Requirements
140.543	Time Standards for Filing Cost Reports
140.544	Access to Cost Reports (Repealed)
140.545	Penalty for Failure to File Cost Reports
140.550	Update of Operating Costs
140.551	General Service Costs Updates
140.552	Nursing and Program Costs
140.553	General Administrative Costs Updates
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- 140.926 Client Eligibility (Repealed)
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- 140.930 Reimbursement
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- 140.946 Hospital Participation in ICARE Program Negotiations (Recodified)
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- 140.966 Transfer of Recipients (Recodified)
- 140.968 Validity of Contracts (Recodified)
- 140.970 Termination of ICARE Contracts (Recodified)
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AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the

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Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective

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December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140. Table H and 140. Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147. Table A and 147. Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended

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at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended

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at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244,

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effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24

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Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended

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at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; preemptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; preemptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; preemptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; preemptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009; emergency amendment at 33 Ill. Reg. 10800, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 11287, effective July 14, 2009; amended at 33 Ill. Reg. 11938, effective August 17, 2009; amended at 33 Ill. Reg. 12227, effective October 1, 2009; emergency amendment at 33 Ill. Reg. 14324, effective October 1, 2009, for a maximum of 150 days; emergency expired February 27, 2010; amended at 33 Ill. Reg. 16573, effective

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November 16, 2009; amended at 34 Ill. Reg. 516, effective January 1, 2010; amended at 34 Ill. Reg. 903, effective January 29, 2010; amended at 34 Ill. Reg. 3761, effective March 14, 2010; amended at 34 Ill. Reg. 5215, effective March 25, 2010; amended at 34 Ill. Reg. 19517, effective December 6, 2010; amended at 35 Ill. Reg. 394, effective December 27, 2010; amended at 35 Ill. Reg. 7648, effective May 1, 2011.

SUBPART K: MANDATORY MCO ENROLLMENTSection 140.1010 Mandatory Enrollment in MCOs

- a) To the extent allowed by federal law and regulations, the Department may require individuals to enroll with a Managed Care Organization (MCO) under contract with the Department and to receive some or all of their medical benefits through that MCO.
- b) HFS shall send a notice to each individual for whom enrollment in a MCO is mandatory, notifying the individual of the need to enroll with an MCO and explaining the options for doing so. If the individual has not chosen an MCO within 30 days after the date of the first notice, the Department shall send a second notice to the individual that the Department will assign him or her to an MCO if he or she does not choose one.
- c) Individuals who have not chosen an MCO within 60 days after the date of their first notice shall be assigned to an MCO by HFS. The algorithm used in the default enrollment process shall be in compliance with 42 CFR 438.50. The individuals will be mailed a notice to inform them of their assigned MCO. Assignment to an MCO shall be effective no sooner than 60 days after the date that the first notice is mailed by the Department. An individual and the MCO with whom that individual is enrolled will receive notice of the enrollment.
- d) Individuals may change MCOs within the first 90 days after the effective date of their enrollment. An individual who changes enrollment within the first 90 days may change MCO again within 90 days after enrollment in the second MCO. After the first 90 days or, in the case of an individual who changed twice, after the second enrollment, an individual may not change his or her enrollment until the end of the 12-month period following enrollment in the current plan.
- e) If an individual enrolled in an MCO loses Medical Assistance eligibility and his or her Medical Assistance eligibility is reinstated within 60 days, that individual

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will be enrolled with the MCO with which he or she was enrolled when Medical Assistance eligibility terminated.

- f) In circumstances in which an individual does not have a choice of MCO, the procedures outlined in subsections (b) through (e) shall be followed for choosing a primary care provider.
- g) For purposes of this Section, Managed Care Organization includes any entity with a contract for a Care Coordination Program pursuant to Section 5-30 of the Public Aid Code [305 ILCS 5/5-30], Section 23 of the Children's Health Insurance Program Act [215 ILCS 106/23] or Section 56 of the Covering All Kids Health Insurance Act [215 ILCS 170/56]. Any contract subject to this Section shall have outcome measures, enrollee protections to assure quality and access, and financial accountability for the contractor based on quality measures.

(Source: Added at 35 Ill. Reg. 7648, effective May 1, 2011)

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- 1) Heading of the Part: General Administrative Provisions
- 2) Code Citation: 89 Ill. Adm. Code 10
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
10.120	Amendment
10.270	Amendment
10.390	New Section
10.410	Amendment
- 4) Statutory Authority: Implementing Articles I through IX and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IX and 12-13] and P. A. 96-867
- 5) Effective date of amendments: April 29, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in the Illinois Register: September 24, 2010; 34 Ill. Reg. 13579
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: No substantive changes were made to the text of the proposed rulemaking.
- 12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No

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- 15) Summary and Purpose of Rulemaking: Public Act 96-867 provides that applications for aid shall be filed with any local office of the Department of Human Services. In addition, P.A. 96-867 provides that an applicant has the right to have his or her case transferred to another local office of the Department of Human Services for his or her convenience, based on stated factors.

As a result of this rulemaking, clients will be able to file applications at any local office. In addition, they will be able to request that their case be transferred to any local office based on stated factors. Within 5 days of a request for a case transfer, staff will have to transfer the case file, assign a caseworker and notify the client that their case has been transferred per 89 Ill. Adm. Code 10.270. These changes are effective January 1, 2011.

A companion amendment is also being adopted in 89 Ill. Adm. Code 121.

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

Tracie Drew, Chief  
Bureau of Administrative Rules and Procedures  
Department of Human Services  
100 South Grand Avenue East  
Harris Building, 3<sup>rd</sup> Floor  
Springfield, Illinois 62762

217/785-9772

- 17) Do these amendments require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code? No

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

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TITLE 89: SOCIAL SERVICES  
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES  
SUBCHAPTER a: GENERAL PROGRAM PROVISIONS

PART 10  
GENERAL ADMINISTRATIVE PROVISIONS

SUBPART A: APPLICABILITY AND DEFINITIONS

Section	
10.101	Incorporation by Reference
10.110	Applicability
10.120	Definitions
10.130	Assistance Programs
10.140	Assistance Program Restrictions

SUBPART B: RIGHTS AND RESPONSIBILITIES

Section	
10.210	Rights of Clients
10.220	Nondiscrimination
10.225	Grievance Rights of Clients
10.230	Confidentiality of Case Information
10.235	Case Records
10.250	Reporting Change of Circumstances
10.263	Reporting Child Abuse/Neglect
10.268	Reporting Elder Abuse/Neglect
10.270	Notice to Client
10.280	Right to Appeal
10.281	Continuation of Assistance Pending Appeal
10.282	Time Limit for Filing an Appeal
10.283	Examining Department Records
10.284	Child Care
10.290	Voluntary Repayment of Assistance
10.295	Correction of Underpayments
10.300	Recovery of Assistance
10.310	Estate Claims
10.320	Real Property Liens
10.330	Filing and Renewal of Liens

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10.340	Foreclosure of Liens
10.350	Release of Liens
10.360	Personal Injury Claims
10.370	Convictions of Fraud – Eligibility
10.380	Single Conviction of Fraud – Administrative Review Board
<u>10.390</u>	<u>Request for Case Transfer</u>

## SUBPART C: APPLICATION PROCESS

## Section

10.410	Application for Assistance
10.415	Local Office Action on Application for Public Assistance
10.420	Time Limitations on the Disposition of an Application
10.430	Approval of an Application and Initial Authorization of Financial Assistance
10.438	General Assistance Approval Provisions
10.440	Denial of an Application

AUTHORITY: Implementing Articles I through IX and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. I through IX and 12-13].

SOURCE: Emergency rules adopted at 21 Ill. Reg. 9515, effective July 1, 1997, for a maximum of 150 days; adopted at 21 Ill. Reg. 15515, effective November 26, 1997; amended at 22 Ill. Reg. 19816, effective November 1, 1998; amended at 23 Ill. Reg. 6944, effective June 1, 1999; amended at 24 Ill. Reg. 7856, effective May 16, 2000; amended at 24 Ill. Reg. 18153, effective November 30, 2000; amended at 25 Ill. Reg. 7170, effective May 24, 2001; amended at 28 Ill. Reg. 1083, effective December 31, 2003; amended at 28 Ill. Reg. 5650, effective March 22, 2004; amended at 29 Ill. Reg. 8148, effective May 18, 2005; amended at 31 Ill. Reg. 6962, effective April 30, 2007; amended at 31 Ill. Reg. 7638, effective May 15, 2007; amended at 32 Ill. Reg. 4375, effective March 12, 2008; amended at 33 Ill. Reg. 16814, effective November 30, 2009; amended at 33 Ill. Reg. 17345, effective December 14, 2009; amended at 34 Ill. Reg. 10079, effective July 1, 2010; amended at 35 Ill. Reg. 7670, effective April 29, 2011.

## SUBPART A: APPLICABILITY AND DEFINITIONS

**Section 10.120 Definitions**

"AABD" or "Aid to the Aged, Blind or Disabled" – Financial assistance and medical assistance available to individuals who have been determined to be aged, blind or disabled as defined by the Social Security Administration.

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"Adequate Consideration" – The receipt of goods, monies or services at least in the amount of the fair market value of the property sold.

"Adult Cases" – A case in which no child is included in the assistance unit.

"Adverse Action" – Any action that reduces SNAP benefits or terminates participation in SNAP within a certification period.

"AFDC-F" – Medical Assistance for an eligible child under DCFS guardianship.

"Agency Error" – An action or inaction of the Department resulting in assistance benefits being furnished to or in behalf of a client for which the client is not eligible.

"Applicant" – An individual requesting assistance by completion of a signed, written application form or a person in whose behalf a signed written application form requesting assistance is completed.

"Application" – A request for assistance by means of a completed, signed designated form. For SNAP purposes, only a name, address and signature are needed on the form.

"Assistance Unit" – The individual or individuals living together for whom the Department determines eligibility and, if eligible, provides financial and/or medical assistance as one unit.

"Beneficiary" – Any person nominated in a will to receive an interest in property other than in a fiduciary capacity.

"Caretaker Relative" or "Specified Relative" – A relative, as specified in this definition, with whom a child must live to be eligible for TANF and who is providing care, supervision and a home for the child.

Blood or adoptive relatives within the fifth degree of kinship:

Father – Mother

Brother – Sister

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Grandmother – Grandfather (including up to great-great-great)

Uncle – Aunt (including up to great-great)

Nephew – Niece (including up to great-great)

First Cousin

First Cousin once removed (child of first cousin)

Second Cousin (child of great-aunt/uncle)

Step-Relatives:

Step-Father – Step-Mother

Step-Brother – Step-Sister

Person who is or has been married to one of the above relatives.

"Categorical Assistance Programs" – TANF, AABD and related MANG programs.

"Categorically Eligible" – The meeting of all eligibility requirements for a categorical assistance program other than financial need.

"Certification for SNAP" – Authorization of eligibility of a household for SNAP.

"Certification Period" – The period of time for which a household is authorized to participate in SNAP.

"Certifying Office" – The DHS local office or General Assistance unit office responsible for certification of SNAP participants.

"Child and Family Assistance Case" – A General Assistance case in which case eligibility is based on pregnancy or the presence of an eligible child.

"Client" – The adult in the family or unit applying for assistance or receiving assistance on behalf of the family.

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"Client Error" – A client's mistake, misunderstanding, misrepresentation or concealment of information or failure to report information promptly that results in financial and/or medical assistance being paid to or in behalf of a recipient for which the recipient is not eligible.

"Correspondent" – A specific individual who has been legally designated to handle the affairs of another individual, that is, parents, court-appointed guardian or conservator.

"DCFS" – Illinois Department of Children and Family Services.

"Department" – The Illinois Department of Human Services.

"Dependent Child" – A child age 18 or under who is living with a relative. If age 18, the child must be a full-time high school (or equivalent) student.

"Disbursing Order" – An invoice voucher form given to a client authorizing a vendor to provide specified goods and/or services.

"Disposition of an Application" – The determination of eligibility or ineligibility.

"Diverted Income" – Earned or unearned income of a parent used to meet the needs of ineligible person or persons, including the parent, their dependent child or children or their spouse.

"DOC" – Illinois Department of Corrections.

"DOL" – Illinois Department of Labor.

"Earmarked Income" – Income restricted for the use of an individual by court order or by legal stipulation of a contributor. Only income of a child may be considered earmarked for Departmental purposes. The income of an eligible child who has siblings in the home receiving TANF financial assistance cannot be earmarked.

"Earned Income" – Pay derived through the receipt of wages or salary for services performed as an employee or profits from activity in which the individual is self-employed.

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"Effective Date" – The date for which case action is authorized.

"Enrolled MANG Participant" – Person or unit meeting the nonfinancial factors of eligibility.

"Established 12-Month Period" – The period of 12 calendar months over which income is compared to the applicable MANG standard.

"Estate" – All real and personal property within an individual's estate as provided in Illinois probate law. For a decedent who received benefits under a long term care insurance policy in connection with which assets were disregarded, the term "estate" includes all real and personal property in which the individual had legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a survivor, heir or assignee of the deceased person through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.

"Expedited Issuance" – Authorization of SNAP benefits after the household has been determined to be destitute or to have zero net income.

"Expedited Service" – An immediate processing of a SNAP application and determination of eligibility for expedited issuance.

"Final Administrative Decision" – A decision made by the Department as a result of an appeal. It either upholds or reverses the appealed action or determines a lack of jurisdiction.

"Financial Assistance" – Public assistance paid in the form of a cash benefit to a recipient for income maintenance needs. Medical assistance and SNAP benefits are not considered financial assistance.

"Financial Factors of Eligibility" – Income, assets and Department levels of assistance.

"Financially Eligible" – The meeting of all financial factors of eligibility.

"Fiscal Month" – Begins on a given day in one calendar month and ends on the day prior to the same given day in the next calendar month.

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"FNS" – The Food and Nutrition Service of the United States Department of Agriculture.

"Full-Time Employment" – Employment of 30 hours per week or more.

"GA" or "General Assistance" – Financial and medical assistance available to eligible needy families or individuals who are ineligible to receive assistance through a categorical assistance program.

"GA Community Work and Training Program" – A program, applicable to GA outside the City of Chicago only, designed to increase employability of General Assistance recipients through constructive work experience, adult education, vocational training and gainful employment.

"Grant" – The total amount of a monthly financial assistance payment.

"Grant Cases" – Public assistance cases authorized for financial assistance payments to the recipient.

"Head of Household" – The person in whose name application is made for participation in SNAP. This person is normally the individual who is the household's primary source of income.

"Hearing" – The actual presentation and consideration of the issue under appeal before a hearing officer of the Department.

"Heir" – Any person entitled under the statutes to an interest in property of a decedent.

"HFS" – Illinois Department of Healthcare and Family Services, formerly known as the Illinois Department of Public Aid (DPA).

"Initial Prorated Entitlement" or "IPE" – Financial assistance to cover the period from the initial point of eligibility (application for assistance or initial needs of a person being added to the assistance unit) through two days after the mailing date of the first regular monthly assistance warrant.

"In-Kind Income" – Income received by or paid in behalf of an individual in a

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form other than money.

"Interim Assistance" – Assistance furnished to or in behalf of an individual financed totally from State and/or local funds for basic maintenance needs and furnished during the period beginning with the month in which the individual filed an application for Supplemental Security Income (SSI) and for which the individual was found eligible.

"Local Governmental Unit" – Every county, city, village, incorporated town or township charged with the duty of providing public aid under General Assistance and County Veterans Assistance Commissions providing assistance to indigent war veterans and their families.

"Local Office" – Department of Human Services Division of Human Capital Development office that serves clients ~~living within a designated geographical area~~.

"Lump-Sum Payment" – An extraordinary or non-recurring income payment received by a client.

"MAG" or "Medical Assistance Grant" – Medical assistance paid on behalf of a recipient of financial assistance.

"MANG" or "Medical Assistance No Grant" – Medical assistance paid on behalf of a recipient of categorical assistance who is not receiving financial assistance.

"MANG(AABD)" – Medical assistance available to individuals who have sufficient income and assets to meet all maintenance needs other than medical care and who are receiving Supplemental Security Income benefits or who are determined to be aged, blind or disabled by the Department of Human Services.

"MANG(C)" – Medical Assistance to Needy Families with Children, which is available to families with one or more children who would qualify for TANF on the basis of non-financial eligibility factors but have sufficient income and assets to meet all maintenance needs other than medical care.

"Medicaid" – Medical assistance issued by the Department under provisions of Title XIX of the Social Security Act (42 USC 1396); MAG and MANG.

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"Medical Assistance" – Medicaid.

"MediPlan Card" – A document that identifies individuals for whom HFS will pay for essential medical services and supplies.

"Migrant Worker" – Any person residing temporarily in and employed in Illinois who moves seasonally from one place to another for the purpose of employment in agricultural activities, including the planting, raising or harvesting of any agricultural or horticultural commodities and the handling, packing or processing of those commodities on the farm where produced or at the point of first processing.

"OASDI" or "Old Age, Survivors, and Disability Insurance" – Often termed "Social Security".

"OJT" – On-the-job training programs sponsored through the TANF Program, Supplemental Nutrition Assistance Employment and Training Program or WIA.

"Participant" – A person taking part in SNAP or a Departmental employment and training program.

"Recipient" – An individual who receives benefits under an assistance program.

"SNAP" – Supplemental Nutrition Assistance Program, formerly known as the Food Stamp Program. A food and nutrition supplement program available to individuals and families.

"SNAP Benefits" – The cash value of benefits that a SNAP unit receives from the program.

"SNAP Household" or "SNAP Unit" – For purposes of SNAP, a household or unit is defined as any of the following:

An individual living alone;

An individual living with others, who customarily purchases food and prepares meals for home consumption separate and apart from others;

A group of individuals who live together and customarily purchase food

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and prepare meals together for home consumption or who, because of their relationship, are required to qualify for SNAP as a unit.

"Specified Relative" – Same as caretaker relative.

"Spendedown" – The amount by which a client's nonexempt income during the eligibility period exceeds the MANG income and asset standards.

"SSA" – The Social Security Administration of the Department of Health and Human Services.

"SSI" or "Supplemental Security Income" – A program administered by the Social Security Administration providing monthly aid to aged, blind and disabled individuals.

"Student" – An individual who is enrolled at least half time (as defined by the institution) in any elementary/middle school, high school, vocational school, technical school, training program or institution of higher education. Enrollment in a mail, self-study or correspondence course does not meet the definition of a student.

"Supervision" – Exercising of responsibility for the child's welfare by the caretaker.

"Supplemental Nutrition Assistance Employment and Training Program" – Employment and training program for SNAP recipients.

"TANF" or "Temporary Assistance for Needy Families" – Financial and medical assistance available to families with one or more dependent children.

"Temporary Caretaker" – Another individual temporarily acting as a caretaker (not included in the assistance unit) when no caretaker relative is available.

"UI" – Unemployment Insurance Benefits.

"Unearned Income" – All income other than earned income.

"Vendor Payment" – Direct payment to vendors for items or services provided to clients.

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"WIA" – The federal Workforce Investment Act (29 USC 2801 et seq.).

"Work Experience" – A Department program that provides experience in a job.

(Source: Amended at 35 Ill. Reg. 7670, effective April 29, 2011)

## SUBPART B: RIGHTS AND RESPONSIBILITIES

**Section 10.270 Notice to Client**

- a) Every applicant for assistance shall be sent or given a written notice of disposition of the application.
- b) Every recipient for assistance shall be sent or given a written notice whenever assistance is reduced or discontinued.
- c) Notices denying, reducing, or discontinuing assistance shall contain the following information:
  - 1) A clear statement of the action being taken.
  - 2) A clear statement of the reason for the action.
  - 3) A reference to the statute, rule, or policy provision under the authority of which the action is taken. From March 1997 through March 1998, references to provisions of the Department's policy manuals using the numbering system in use in 1996 shall be deemed to be references to the corresponding provisions of the new numbering system introduced in 1997.
  - 4) A complete statement of the client's right to appeal (see subsection (d) below and Sections 10.280 through 10.282).
- d) Timely Notice
  - 1) All notices concerning local office reduction or discontinuance of assistance shall be "timely". A "timely" notice shall be mailed or given at least ten calendar days prior to the date the reduction or discontinuance

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will occur, and shall inform the client that if the client files an appeal by the date the reduction or discontinuance will occur, his or her assistance will be continued at its previous level, pending the results of the appeal unless the client specifically requests that the assistance benefits not be continued. The notice shall be dated with the date it is mailed or given. (Day one of the ten-day period is the day following the date on the notice. Day ten may be no later than the date the reduction or discontinuance will occur.)

- 2) Notices sent concerning reduction or discontinuance of assistance by agency action initiated centrally may be either "timely" or "adequate", as defined by federal regulation. When timely notice is not required and an adequate notice is sent less than ten days before the date of change, the client may receive continued benefits if the appeal is filed within ten days after the date of notice. (See 89 Ill. Adm. Code 112.302.)

e) Temporary Assistance for Needy Families

- 1) Every recipient who makes a written request for a grant increase or a special authorization shall be sent or given written notice of the disposition of the request within 45 days after the date of the request.
- 2) Every recipient who makes a request for ~~Crisis~~General Assistance (89 Ill. Adm. Code 116) shall be sent or given a written notice of the disposition of the request within 45 days after the date of the request.

f) A notice will be sent that contains the name of, and contact information for, the caseworker when a case is transferred per Section 10.390

g) f) Approval of General Assistance as a ~~Result~~result of ~~Cancellation~~ancellation of TANF or AABD or ~~Reduction~~reduction of TANF (Applicable Only in City of Chicago)

- 1) A notice of intended cancellation or reduction of benefits is sent to a TANF or AABD recipient, in the City of Chicago, whose assistance is discontinued or a person deleted from the assistance unit (AFDC only) for one of the following reasons:
  - A) AABD: no longer blind, disabled.

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B) TANF: no longer an eligible child in the home.

- 2) If a recipient from one of the programs listed in subsection ~~(g)~~(f)(1) of this Section applies for General Assistance (GA) within 30 days after the notice of cancellation or reduction of benefits and if that recipient is determined to be eligible for GA, such benefits shall be authorized with no gap in assistance (see also Section 10.430).

~~h)g)~~ ~~SNAPFood Stamp~~ households shall be notified:

- 1) If there is no change in benefits following submission of a change report form.
- 2) If ~~SNAPfood stamp~~ benefits are being reduced or discontinued, the following additional information shall be included on the notice:
- A) the telephone number of the local DHS office;
- B) a statement indicating the household's liability for benefits received while waiting for a fair hearing decision, if the decision is adverse to the household; and
- C) a statement indicating the general availability of outside individuals or organizations providing free legal representation and the telephone numbers of those individuals or organizations.
- 3) A notice of approval shall be sent to eligible households by the 30<sup>th</sup> day following the date of application. If the household is found not eligible to participate, the notice of denial shall be sent by the 30<sup>th</sup> day following the date of application.
- 4) If the local office cannot act on an application by the 30<sup>th</sup> day because the case file is incomplete due to a household's delay, a notice of denial shall be sent on the 30<sup>th</sup> day. However, the household has an additional 30 days to complete the application. If the delay is caused by the local office, a notice of pending status shall be sent to the household by the 30<sup>th</sup> day.

(Source: Amended at 35 Ill. Reg. 7670, effective April 29, 2011)

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**Section 10.390 Request for Case Transfer**

- a) Once an applicant is determined eligible for assistance, he or she has a right to request to have the case transferred to another local office for his or her convenience, based upon one of the following factors:
- 1) the location of his or her employer;
  - 2) the location of his or her child care provider;
  - 3) access to reliable transportation; or
  - 4) the location of a social service provider that he or she sees on a regular basis.
- b) Within five business days after the request for transfer, the local office will transfer the case, assign a caseworker, make appropriate entries in the computer system, and issue a written notice to the recipient per Section 10.270.
- c) The location of the case may be reconsidered, based upon the criteria in this Section, per the recipient's request or at the time of redetermination of eligibility.

(Source: Added at 35 Ill. Reg. 7670, effective April 29, 2011)

## SUBPART C: APPLICATION PROCESS

**Section 10.410 Application for Assistance**

- a) An application is a request for assistance on a Department of Human Services (Department) form or a DHS web application submitted electronically that has been completed to the best of the client's knowledge and ability.
- b) The application must contain a name, address, and signature (or signatures). A web application submitted and received electronically over the Internet does not require a signature to begin the application process for cash and medical assistance, but is required to authorize cash and medical benefits. An electronic signature is used for SNAPfood stamp applications submitted and received electronically. If the application does not contain a name, address, and signature

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(or signatures), the local office shall return the application to the sender to obtain the missing information.

- 1) If a person is homeless, he or she may use the address of a friend or relative, supervised shelter, church, halfway house, or similar facility.
  - 2) If a person is homeless and does not have a permanent address, he or she may use the address of the local office where he or she applied or where his or her case is currently active~~that is closest to where he or she is living.~~
- c) The application must be signed by the applicant with the following exceptions:
- 1) When a conservator has been appointed for the applicant, the conservator must sign the application.
  - 2) When the applicant is physically or mentally unable to sign the application, the application may be signed by someone acting responsibly on behalf of the applicant.
  - 3) When application is made on behalf of a child, the child's caretaker must sign the application.
  - 4) When the applicant has appointed an authorized representative with the Department. (An authorized representative is a person authorized by the applicant to act on his or her behalf.)
- d) Application for medical assistance may be made on behalf of a deceased person. In order for payment to be made by the Department for the funeral and burial expenses of the decedent, the completed application must be received in the local office not more than 30 calendar days after the individual's death, excluding the day on which death occurred, unless delay in receipt of the form occurred through no fault of the individual applying.
- e) The applicant may be assisted by the Department and by individuals of the applicant's choice in completing the application.
- f) The date of application shall be the date a completed application is received by any~~the~~ local office ~~serving the area of the State in which the applicant lives~~, with the following exceptions:

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- 1) For applications completed by pregnant women and children under age 18 at a disproportionate share hospital or federally-qualified health center, the date the application is signed by the applicant shall be the date of application.
- 2) When an application is faxed to a local office or a web application is submitted and received over the Internet after 5:00 P.M. on a workday, or on a weekend or holiday, the application date is the next workday following the date the application is received in the local office.

(Source: Amended at 35 Ill. Reg. 7670, effective April 29, 2011)

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- 1) Heading of the Part: Supplemental Nutrition Assistance Program (SNAP)
- 2) Code Citation: 89 Ill. Adm. Code 121
- 3) Section Number: 121.10                      Adopted Action:  
Amendment
- 4) Statutory Authority: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13] and P.A. 96-867
- 5) Effective Date of Amendment: April 29, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal published in the Illinois Register: September 24, 2010; 34 Ill. Reg. 13597
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: No substantive changes were made to the text of the proposed rulemaking.
- 12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
121.63	Amendment	July 9, 2010; 34 Ill. Reg. 8852
121.20	Amendment	February 4, 2011; 35 Ill. Reg. 1856

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- 15) Summary and Purpose of Rulemaking: Public Act 96-867 provides that in Supplemental Nutrition and Assistance Program (SNAP) cases in which an applicant or recipient reports earned income, the applicant's or recipient's employment shall be presumed to be a hardship for purposes of scheduling an in-person meeting with a representative of the Department of Human Services and an in-person meeting shall be waived.

As a result of this rulemaking, employed clients will not be required to come to the local office for a face-to-face interview. However, the Department will conduct a face-to-face interview if the household requests one. This change is effective January 1, 2011.

Companion amendments are also being adopted in 89 Ill. Adm. Code 10.

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

Tracie Drew, Chief  
Bureau of Administrative Rules and Procedures  
Department of Human Services  
100 South Grand Avenue East  
Harris Building, 3<sup>rd</sup> Floor  
Springfield, Illinois 62762

217/785-9772

- 17) Does this amendment require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code? No

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

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TITLE 89: SOCIAL SERVICES  
CHAPTER IV: DEPARTMENT OF HUMAN SERVICES  
SUBCHAPTER b: ASSISTANCE PROGRAMSPART 121  
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

## SUBPART A: APPLICATION PROCEDURES

## Section

- 121.1 Application for Assistance
- 121.2 Time Limitations on the Disposition of an Application
- 121.3 Approval of an Application and Initial Authorization of Assistance
- 121.4 Denial of an Application
- 121.5 Client Cooperation
- 121.6 Emergency Assistance
- 121.7 Expedited Service
- 121.8 Express Stamps Application Project
- 121.10 Interviews

## SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

## Section

- 121.18 Work Requirement
- 121.19 Ending a Voluntary Quit Disqualification (Repealed)
- 121.20 Citizenship
- 121.21 Residence
- 121.22 Social Security Numbers
- 121.23 Work Registration/Participation Requirements
- 121.24 Individuals Exempt from Work Registration Requirements
- 121.25 Failure to Comply with Work Provisions
- 121.26 Periods of Sanction
- 121.27 Voluntary Job Quit/Reduction in Work Hours
- 121.28 Good Cause for Voluntary Job Quit/Reduction in Work Hours
- 121.29 Exemptions from Voluntary Quit/Reduction in Work Hours Rules

## SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

## Section

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121.30	Unearned Income
121.31	Exempt Unearned Income
121.32	Education Benefits (Repealed)
121.33	Unearned Income In-Kind
121.34	Lump Sum Payments and Income Tax Refunds
121.40	Earned Income
121.41	Budgeting Earned Income
121.50	Exempt Earned Income
121.51	Income from Work/Study/Training Programs
121.52	Earned Income from Roomers or Boarders
121.53	Income From Rental Property
121.54	Earned Income In-Kind
121.55	Sponsors of Aliens
121.57	Assets
121.58	Exempt Assets
121.59	Asset Disregards

## SUBPART D: ELIGIBILITY STANDARDS

Section	
121.60	Net Monthly Income Eligibility Standards
121.61	Gross Monthly Income Eligibility Standards
121.62	Income Which Must Be Annualized
121.63	Deductions from Monthly Income
121.64	Food Stamp Benefit Amount

## SUBPART E: HOUSEHOLD CONCEPT

Section	
121.70	Composition of the Assistance Unit
121.71	Living Arrangement
121.72	Nonhousehold Members
121.73	Ineligible Household Members
121.74	Strikers
121.75	Students
121.76	Categorically Eligible Households

## SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

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## Section

- 121.80 Fraud Disqualification (Renumbered)
- 121.81 Initiation of Administrative Fraud Hearing (Repealed)
- 121.82 Definition of Fraud (Renumbered)
- 121.83 Notification To Applicant Households (Renumbered)
- 121.84 Disqualification Upon Finding of Fraud (Renumbered)
- 121.85 Court Imposed Disqualification (Renumbered)
- 121.90 Monthly Reporting and Retrospective Budgeting (Repealed)
- 121.91 Monthly Reporting (Repealed)
- 121.92 Budgeting
- 121.93 Issuance of Food Stamp Benefits
- 121.94 Replacement of the EBT Card or SNAP Benefits
- 121.95 Restoration of Lost Benefits
- 121.96 Uses for SNAP Benefits
- 121.97 Supplemental Payments
- 121.98 Client Training Brochure for the Electronic Benefits Transfer (EBT) System
- 121.105 State Food Program (Repealed)
- 121.107 New State Food Program
- 121.108 Transitional Food Stamp (TFS) Benefits
- 121.120 Redetermination of Eligibility
- 121.125 Simplified Reporting Redeterminations
- 121.130 Residents of Shelters for Battered Women and their Children
- 121.131 Fleeing Felons and Probation/Parole Violators
- 121.135 Incorporation By Reference
- 121.136 Food and Nutrition Act of 2008
- 121.140 Small Group Living Arrangement Facilities and Drug/Alcoholic Treatment Centers
- 121.145 Quarterly Reporting (Repealed)

## SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

## Section

- 121.150 Definition of Intentional Violations of the Program
- 121.151 Penalties for Intentional Violations of the Program
- 121.152 Notification To Applicant Households
- 121.153 Disqualification Upon Finding of Intentional Violation of the Program
- 121.154 Court Imposed Disqualification

## SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

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## Section

121.160	Persons Required to Participate
121.162	Program Requirements
121.163	Vocational Training
121.164	Orientation (Repealed)
121.165	Community Work
121.166	Assessment and Employability Plan (Repealed)
121.167	Counseling/Prevention Services
121.170	Job Search Activity
121.172	Basic Education Activity
121.174	Job Readiness Activity
121.176	Work Experience Activity
121.177	Illinois Works Component (Repealed)
121.178	Job Training Component (Repealed)
121.179	JTPA Employability Services Component (Repealed)
121.180	Grant Diversion Component (Repealed)
121.182	Earnfare Activity
121.184	Sanctions for Non-cooperation with Food Stamp Employment and Training
121.186	Good Cause for Failure to Cooperate
121.188	Supportive Services
121.190	Conciliation
121.200	Types of Claims (Recodified)
121.201	Establishing a Claim for Intentional Violation of the Program (Recodified)
121.202	Establishing a Claim for Unintentional Household Errors and Administrative Errors (Recodified)
121.203	Collecting Claim Against Households (Recodified)
121.204	Failure to Respond to Initial Demand Letter (Recodified)
121.205	Methods of Repayment of Food Stamp Claims (Recodified)
121.206	Determination of Monthly Allotment Reductions (Recodified)
121.207	Failure to Make Payment in Accordance with Repayment Schedule (Recodified)
121.208	Suspension and Termination of Claims (Recodified)

## SUBPART I: WORK REQUIREMENT FOR FOOD STAMPS

## Section

121.220	Work Requirement Components (Repealed)
121.221	Meeting the Work Requirement with the Earnfare Component (Repealed)
121.222	Volunteer Community Work Component (Repealed)

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- 121.223 Work Experience Component (Repealed)
- 121.224 Supportive Service Payments to Meet the Work Requirement (Repealed)
- 121.225 Meeting the Work Requirement with the Illinois Works Component (Repealed)
- 121.226 Meeting the Work Requirement with the JTPA Employability Services Component (Repealed)

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13].

SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4, 1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 18, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (by adding Section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690,

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effective October 1, 1984; preemptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 6804, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; preemptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 8, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; preemptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; preemptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; preemptory amendment at 10 Ill. Reg. 7941, effective May 1, 1986; amended at 10 Ill. Reg. 14692, effective August 29, 1986; preemptory amendment at 10 Ill. Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; preemptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; preemptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; preemptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; preemptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; preemptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 20161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 13619, effective August 14, 1989; preemptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; preemptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 14 Ill. Reg. 16983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 11957, effective August 12, 1991; preemptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 757, effective January 1, 1992, for a maximum of 150

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days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; preemptory amendment at 16 Ill. Reg. 16345, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 7, 1993, for a maximum of 150 days; preemptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; emergency amendment at 18 Ill. Reg. 2509, effective January 27, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 3427, effective February 28, 1994; amended at 18 Ill. Reg. 8921, effective June 3, 1994; amended at 18 Ill. Reg. 12829, effective August 5, 1994; amended at 18 Ill. Reg. 14103, effective August 26, 1994; amended at 19 Ill. Reg. 5626, effective March 31, 1995; amended at 19 Ill. Reg. 6648, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 12705, effective September 1, 1995, for a maximum of 150 days; preemptory amendment at 19 Ill. Reg. 13595, effective October 1, 1995; amended at 20 Ill. Reg. 1593, effective January 11, 1996; preemptory amendment at 20 Ill. Reg. 2229, effective January 17, 1996; amended at 20 Ill. Reg. 7902, effective June 1, 1996; amended at 20 Ill. Reg. 11935, effective August 14, 1996; emergency amendment at 20 Ill. Reg. 13381, effective October 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 13668, effective October 8, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 3156, effective February 28, 1997; amended at 21 Ill. Reg. 7733, effective June 4, 1997; recodified from the Department of Public Aid to the Department of Human Services at 21 Ill. Reg. 9322; emergency amendment at 22 Ill. Reg. 1954, effective January 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 5502, effective March 4, 1998; amended at 22 Ill. Reg. 7969, effective May 15, 1998; emergency amendment at 22 Ill. Reg. 10660, effective June 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 12167, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16230, effective September 1, 1998; amended at 22 Ill. Reg. 19787, effective October 28, 1998; emergency amendment at 22 Ill. Reg. 19934, effective November 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 20099, effective November 1, 1998; emergency amendment at 23 Ill. Reg. 2601, effective February 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 3374, effective March 1, 1999; amended at 23 Ill. Reg. 7285, effective June 18, 1999; emergency amendment at 23 Ill. Reg. 13253, effective October 13, 1999, for a maximum of 150 days; emergency amendment at 24 Ill. Reg. 3871, effective February 24, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 4180, effective March 2, 2000; amended at 24 Ill. Reg. 10198, effective June 27, 2000; amended at 24 Ill. Reg. 15428, effective October 10, 2000; emergency amendment at 24 Ill. Reg. 15468, effective October 1, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 845, effective January 5, 2001; amended at 25 Ill. Reg. 2423, effective January 25, 2001; emergency amendment at 25 Ill. Reg. 2439, effective January 29, 2001, for a

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF ADOPTED AMENDMENT

maximum of 150 days; emergency amendment at 25 Ill. Reg. 3707, effective March 1, 2001, for a maximum of 150 days; emergency expired July 28, 2001; amended at 25 Ill. Reg. 7720, effective June 7, 2001; amended at 25 Ill. Reg. 10823, effective August 12, 2001; amended at 25 Ill. Reg. 11856, effective August 31, 2001; emergency amendment at 25 Ill. Reg. 13309, effective October 1, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 151, effective January 1, 2002; amended at 26 Ill. Reg. 2025, effective February 1, 2002; amended at 26 Ill. Reg. 13530, effective September 3, 2002; preemptory amendment at 26 Ill. Reg. 15099, effective October 1, 2002; amended at 26 Ill. Reg. 16484, effective October 25, 2002; amended at 27 Ill. Reg. 2889, effective February 7, 2003; expedited correction at 27 Ill. Reg. 14262, effective February 7, 2003; amended at 27 Ill. Reg. 4583, effective February 28, 2003; amended at 27 Ill. Reg. 7273, effective April 7, 2003; amended at 27 Ill. Reg. 12569, effective July 21, 2003; preemptory amendment at 27 Ill. Reg. 15604, effective October 1, 2003; amended at 27 Ill. Reg. 16108, effective October 6, 2003; amended at 27 Ill. Reg. 18445, effective November 20, 2003; amended at 28 Ill. Reg. 1104, effective December 31, 2003; amended at 28 Ill. Reg. 3857, effective February 13, 2004; amended at 28 Ill. Reg. 10393, effective July 6, 2004; preemptory amendment at 28 Ill. Reg. 13834, effective October 1, 2004; emergency amendment at 28 Ill. Reg. 15323, effective November 10, 2004, for a maximum of 150 days; emergency expired April 8, 2005; amended at 29 Ill. Reg. 2701, effective February 4, 2005; amended at 29 Ill. Reg. 5499, effective April 1, 2005; preemptory amendment at 29 Ill. Reg. 12132, effective July 14, 2005; emergency amendment at 29 Ill. Reg. 16042, effective October 4, 2005, for a maximum of 150 days; emergency expired March 2, 2006; preemptory amendment at 29 Ill. Reg. 16538, effective October 4, 2005; emergency amendment at 30 Ill. Reg. 7804, effective April 6, 2006, for a maximum of 150 days; emergency expired September 2, 2006; amended at 30 Ill. Reg. 11236, effective June 12, 2006; amended at 30 Ill. Reg. 13863, effective August 1, 2006; amended at 30 Ill. Reg. 15681, effective September 12, 2006; preemptory amendment at 30 Ill. Reg. 16470, effective October 1, 2006; amended at 31 Ill. Reg. 6991, effective April 30, 2007; amended at 31 Ill. Reg. 10482, effective July 9, 2007; amended at 31 Ill. Reg. 11318, effective July 23, 2007; preemptory amendment at 31 Ill. Reg. 14372, effective October 1, 2007; amended at 32 Ill. Reg. 2813, effective February 7, 2008; amended at 32 Ill. Reg. 4380, effective March 12, 2008; amended at 32 Ill. Reg. 4813, effective March 18, 2008; amended at 32 Ill. Reg. 9621, effective June 23, 2008; preemptory amendment at 32 Ill. Reg. 16905, effective October 1, 2008; preemptory amendment to Sections 121.94(c), 121.96(d)(2) and 121.150(b) suspended at 32 Ill. Reg. 18908, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 200, effective February 5, 2009; preemptory amendment repealed by emergency rulemaking at 33 Ill. Reg. 3514, effective February 5, 2009, for a maximum of 150 days; preemptory amendment at 32 Ill. Reg. 18092, effective November 15, 2008; emergency amendment at 33 Ill. Reg. 4187, effective February 24, 2009, for a maximum of 150 days; emergency expired July 23, 2009; preemptory amendment at 33 Ill. Reg. 5537, effective April 1, 2009; emergency amendment at 33 Ill. Reg. 11322, effective July 20, 2009, for

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a maximum of 150 days; emergency expired December 16, 2009; amended at 33 Ill. Reg. 12802, effective September 3, 2009; amended at 33 Ill. Reg. 14121, effective September 22, 2009; emergency amendment at 33 Ill. Reg. 14627, effective October 13, 2009, for a maximum of 150 days; emergency expired March 11, 2010; amended at 33 Ill. Reg. 16875, effective November 30, 2009; amended at 33 Ill. Reg. 17350, effective December 14, 2009; amended at 34 Ill. Reg. 4777, effective March 17, 2010; amended at 34 Ill. Reg. 5295, effective April 12, 2010; amended at 34 Ill. Reg. 5823, effective April 19, 2010; emergency amendment at 34 Ill. Reg. 6967, effective May 1, 2010, for a maximum of 150 days; emergency expired September 27, 2010; amended at 34 Ill. Reg. 7265, effective May 10, 2010; amended at 34 Ill. Reg. 7685, effective May 18, 2010; amended at 34 Ill. Reg. 12547, effective August 11, 2010; peremptory amendment at 34 Ill. Reg. 15543, effective October 1, 2010; amended at 35 Ill. Reg. 1042, effective January 7, 2011; amended at 35 Ill. Reg. 7688, effective April 29, 2011.

## SUBPART A: APPLICATION PROCEDURES

**Section 121.10 Interviews**

- a) All applicant households, including those submitting applications by mail, shall have face-to-face interviews in a local office with a qualified eligibility worker prior to initial certification and all redeterminations. For earned income, non-assistance SNAP only households, and FamilyCare SNAP households, an interview is required at every other redetermination (see Section 121.125). For persons completing a redetermination using the phone interview system, the automated phone interview substitutes for the face-to-face interview.
- b) Interview Process
  - 1) The individual interviewed may be the head of the household, spouse, any other adult member of the household who is sufficiently familiar with the household's circumstances to be able to assist in the determination of eligibility, or an authorized representative (see Section 121.1(e)(1) and (2)). The applicant may bring any person he/she chooses to the interview. Prior to beginning the interview, the applicant shall indicate which persons are not applying for SNAP benefits because they are unable or unwilling to provide alien status verification.
  - 2) The interviewer shall not simply review the information that appears on the application, but shall explore and resolve with the household unclear and incomplete information.

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF ADOPTED AMENDMENT

- 3) Households shall be advised of their rights and responsibilities during the interview, including the appropriate applications processing standard (see Sections 121.2 and 121.7) and the household's responsibility to report changes.
  - 4) The interview shall be conducted as an official and confidential discussion of household circumstances. The applicant's right to privacy shall be protected during the interview. Facilities shall be adequate to preserve the privacy and confidentiality of the interview.
- c) Waiver of Office Interviews
- 1) The office interview shall be waived if requested by any household ~~thatwhich~~ is unable to appoint an authorized representative and ~~thatwhich~~ has no household members able to come to the local office because they are qualifying members as defined in Section 121.61.
  - 2) The office interview shall also be waived for any household:
    - A) ~~containing a household member who is employed; or~~
    - B) on a case-by-case basis for any household ~~thatwhich~~ is unable to appoint an authorized representative and ~~thatwhich~~ has no household members able to come to the local office because of transportation difficulties or similar hardships ~~thatwhich~~ the Department determines warrants a waiver of the office interview. These hardship conditions include, but are not limited to:
      - iA) illness;
      - iiB) care of household member;
      - iiiC) hardships due to residency in a rural area;
      - ivD) prolonged severe weather;
      - vE) ~~work or~~ training hours ~~thatwhich~~ prevent the household from participating in an in-office interview.

## DEPARTMENT OF HUMAN SERVICES

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- 3) ~~The Department will conduct a face-to-face interview if the household requests one. The Department shall determine if the transportation difficulty or hardship reported by a household warrants a waiver of the office interview and shall document in the case file why a request for a waiver was granted or denied.~~
  - 4) The Department has the option of conducting a telephone interview or a home visit for those households for whom the office interview is waived. Home visits shall be used only if the time of the visit is scheduled in advance with the household. However, a home visit interview for redetermination of eligibility for financial assistance/recertification does not have to be scheduled with the household in advance.
  - 5) Waiver of the face-to-face interview does not exempt the household from the verification requirements, although special procedures may be used to permit the household to provide verification and thus obtain its benefits in a timely manner, such as substituting a collateral contact in cases where documentary verification would normally be provided.
  - 6) Waiver of the face-to-face interview shall not affect the length of the household's certification period.
- d) The Department shall schedule all interviews as promptly as possible to ensure the eligible households receive an opportunity to participate within 30 days after the application is filed. If a household fails to appear for the scheduled interview, the Department will issue a Notice of Missed Interview that will inform the household that the household missed its scheduled interview and that the household is responsible for requesting another interview.

(Source: Amended at 35 Ill. Reg. 7688, effective April 29, 2011)

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Practice and Procedure in Administrative Hearings
- 2) Code Citation: 77 Ill. Adm. Code 100
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
100.8	Amended
100.16	Repealed
- 4) Statutory Authority: Section 5-10(a)(i) of the Illinois Administrative Procedure Act [5 ILCS 100/5-10(a)(i)] and Sections 55 through 55.63 of the Civil Administrative Code of Illinois [20 ILCS 2310/55 through 55.63]
- 5) Effective Date of Rulemaking: April 29, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendments Published in Illinois Register: January 7, 2011; 35 Ill. Reg. 343
- 10) Has JCAR issued a Statement of Objection to these rules? No
- 11) Differences between proposal and final version: The following changes were made in response to comments received during the first notice or public comment period:
  1. Section 100.2 was removed from the rulemaking.
  2. In Section 100.8(i), the underlined text referencing Illinois Supreme Court Rule 63 (C) was deleted and the stricken word "On" was reinstated.
  3. In Section 100.8, a new subsection (j) was added.
  4. The subsection label in existing subsection "j)" was stricken and "k)" was inserted.

In addition, various format changes were made in response to the comments from JCAR.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: Section 100.8 has been amended in accordance with the Department's agreement with the Joint Committee on Administrative Rules (JCAR) to expand upon language concerning the disqualification of administrative law judges, in accordance with Section 10-20 of the Illinois Administrative Procedure Act [5 ILCS 100/10-20]. During the First Notice period, at the request of JCAR staff, the Department replaced the reference to the Illinois Supreme Court's rule 63 with language from the rule setting forth criteria for disqualification. Since the Supreme Court rule is no longer being referenced, the addition to Section 100.2 is no longer needed, and this Section was removed from the rulemaking. Section 100.16 has been repealed. The Department no longer uses this procedure. The administrative law judge submits a report and recommendations to the Director in accordance with Section 100.15, and the Director reads the record of each hearing. The procedure in Section 100.16 addressed a situation in which the Director would not have read the record.
- 16) Information and questions regarding these adopted amendments shall be directed to:

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

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

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER a: GENERAL RULES

PART 100  
PRACTICE AND PROCEDURE IN ADMINISTRATIVE HEARINGS

SUBPART A: APPLICABILITY AND DEFINITIONS

Section

- 100.1 Authority and Applicability
- 100.2 Definitions and Referenced Materials

SUBPART B: GENERAL HEARINGS

Section

- 100.3 Parties to Hearings
- 100.4 Appearance – Right to Counsel
- 100.5 Emergency Action
- 100.6 Hearings Requested by Complainants
- 100.7 Initiation of a Contested Case
- 100.8 Motions
- 100.9 Form of Papers
- 100.10 Service
- 100.11 Prehearing Conferences
- 100.12 Discovery
- 100.13 Hearings
- 100.14 Subpoenas
- 100.15 Administrative Law Judge's Report and Recommendations
- 100.16 Proposal for Decision [\(Repealed\)](#)
- 100.17 Final Orders
- 100.18 Records of Proceedings
- 100.19 Miscellaneous

SUBPART C: ADMINISTRATIVE HEARINGS UNDER  
THE SMOKE FREE ILLINOIS ACT

Section

- 100.25 Initiation of a Hearing

## DEPARTMENT OF PUBLIC HEALTH

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100.35	Parties to Hearings
100.40	Right to Counsel
100.45	Prehearing Conference
100.50	Motions
100.55	Discovery
100.60	Hearings
100.70	Report and Recommendations
100.80	Final Order and Payment of Fines
100.90	Record of Hearing

AUTHORITY: Implementing and authorized by Section 5-10(a)(i) of the Illinois Administrative Procedure Act [5 ILCS 100/5-10(a)(i)] and Sections 55 through 55.63 of the Civil Administrative Code of Illinois [20 ILCS 2310/55 through 55.63].

SOURCE: Adopted at 2 Ill. Reg. 38, p. 91, effective September 23, 1978; amended and codified at 4 Ill. Reg. 43, p. 127, effective October 14, 1980; amended at 5 Ill. Reg. 14167, effective December 9, 1981; amended at 6 Ill. Reg. 2235, effective February 2, 1982; amended at 11 Ill. Reg. 1937, effective January 9, 1987; amended at 18 Ill. Reg. 5980, effective April 1, 1994; amended at 21 Ill. Reg. 3208, effective March 3, 1997; amended at 34 Ill. Reg. 11768, effective July 30, 2010; amended at 35 Ill. Reg. 7701, effective April 29, 2011.

## SUBPART B: GENERAL HEARINGS

**Section 100.8 Motions**

- a) Motions, unless made during a hearing, shall be made in writing and shall set forth the relief or order sought and the legal authority for the action requested. Except as otherwise provided in this Part or by a specific statute, motions may seek any relief or order recognized in the Code of Civil Procedure and Rules of the Illinois Supreme Court, and shall include a reference to the applicable Section of the Code or Rules. Motions based on a matter that does not appear of record shall be supported by affidavit.
- b) Written motions shall be titled as to the party making the motion and the nature of the relief sought. The title shall be in capital letters and shall be placed either below the caption or to the right of the caption beneath the docket number. No motion shall be identically titled with any other motion. Examples of properly-titled motions: Respondent's Motion to Dismiss, Respondent's Second Motion to Dismiss.

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENTS

- c) Motions to the pleadings if not raised at the earliest opportunity shall be deemed waived. Motions to the pleadings shall not be granted if the pleadings do not conform to Section 100.7.
- d) The administrative law judge shall not have the authority to dismiss, postpone, vacate, or overturn an Order or Notice issued by the Director, but may make a recommendation to the Director at any time that circumstances merit such a recommendation.
- e) Motions for a continuance shall be granted only for good cause shown. Motions for a continuance shall be in writing and filed at least five working days prior to the hearing. Motions for a continuance shall be made immediately when the party learns that a continuance is needed. Statements as to when the party learned that a continuance was needed, steps that were taken to avoid the continuance, and the current reasons the continuance is needed shall be contained in the motion. After one continuance has been granted to a party, additional continuances may be granted to that party only if:
  - 1) a hearing on the issue of whether to grant the continuance has been held and the administrative law judge finds that the moving party has presented sufficient evidence showing entitlement to another continuance; or
  - 2) there is an emergency; or
  - 3) all parties so stipulate.
- f) Whenever possible, as much of the hearing as possible shall be completed, and only those matters that must be continued shall be continued.
- g) If there is an unforeseen emergency, motions for a continuance may be made by telephone rather than in writing. Motions by telephone shall be made through a conference call involving the administrative law judge and all parties and shall be confirmed within three business days by the filing of a written motion.
- h) Responses shall be in writing unless made at a prehearing conference or a hearing.
- i) On motion made by any party, the administrative law judge who is the subject of the motion shall determine whether he or she should be disqualified on the basis

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of ~~*bias or conflict of interest*~~*bias or conflict of interest*, and shall remove himself or herself if a determination is made that bias or a conflict of interest exists. If the motion is granted, the Director shall appoint a new administrative law judge. *An adverse ruling, in and of itself, shall not constitute bias or conflict of interest.* (Section 10-30 of the IAPA)

- j) The following shall constitute bias or conflict of interest for the purpose of disqualification under subsection (i):
- 1) The judge has a personal bias or prejudice concerning a party or a party's lawyer, or personal knowledge of disputed evidentiary facts concerning the proceeding;
  - 2) The judge served as a lawyer in the matter in controversy, or a lawyer with whom the judge previously practiced law served during that association as a lawyer concerning the matter, or the judge has been a material witness concerning it;
  - 3) The judge was, within the preceding three years, associated in the private practice of law with any law firm or lawyer currently representing any party in the controversy (provided that referral of cases when no monetary interest was retained shall not be deemed an association within the meaning of this subsection (j)) or, for a period of seven years following the last date on which the judge represented any party to the controversy while the judge was an attorney engaged in the private practice of law;
  - 4) The judge knows that any of the following persons has an economic interest in the subject matter in controversy or in a party to the proceeding, or has any other more than minimal interest that could be substantially affected by the proceeding:
    - A) the judge individually;
    - B) a fiduciary;
    - C) the judge's spouse, parent or child, wherever residing; or
    - D) any other member of the judge's family residing in the judge's household.

DEPARTMENT OF PUBLIC HEALTH  
NOTICE OF ADOPTED AMENDMENTS

~~kj~~) Demands for a Bill of Particulars shall not be allowed.

(Source: Amended at 35 Ill. Reg. 7701, effective April 29, 2011)

**Section 100.16 Proposal for Decision (Repealed)**

- ~~a) When the Director has not heard the contested case or read the record and his or her final decision would be adverse to any party other than the Department, a proposal for decision shall be served upon all parties to the proceedings. The proposal for decision shall contain:~~
- ~~1) A statement of the reasons for the proposed decision;~~
  - ~~2) A statement of each issue of fact or law necessary to the proposed decision. (Section 10-45 of the IAPA)~~
- ~~b) The proposal for decision shall be prepared by the persons who conducted the hearing or one who has read the record. (Section 10-45 of the IAPA)~~
- ~~c) Any party adversely affected by the proposed decision shall have 20 days from the receipt of the proposal for decision in which to file written exceptions and a brief. Failure to file written exceptions and a brief in the time provided for in the proposal for decision shall be deemed a waiver of the right to file exceptions and a brief. The Department shall have 10 days to respond to the exceptions or brief.~~
- ~~d) The proposal for decision shall be served on all parties personally or by certified mail.~~
- ~~e) The Director may provide for oral arguments on the proposal for decision. If oral arguments are allowed, they shall be scheduled as convenient to the Director.~~

(Source: Repealed at 35 Ill. Reg. 7701, effective April 29, 2011)

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Physical Fitness Facility Medical Emergency Preparedness Code
- 2) Code Citation: 77 Ill. Adm. Code 527
- 3) Section Number: 527.600                      Adopted Action: Amend
- 4) Statutory Authority: Physical Fitness Facility Medical Emergency Preparedness Act [210 ILCS 74]
- 5) Effective Date of Rulemaking: April 27, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendments Published in Illinois Register: January 21, 2011; 35 Ill Reg. 1331
- 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? No agreements were necessary.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: 77 Ill. Adm. Code 527.600 is amended to implement Public Act 96-1268. This Act deletes the section of the Physical Fitness Facility Medical Emergency Preparedness Act that delegates the responsibility of providing the automated external defibrillator (AED) at all outdoor facilities where the AED is not housed in a building within 300 feet of the outdoor physical fitness facility.

DEPARTMENT OF PUBLIC HEALTH

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

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

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

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

## DEPARTMENT OF PUBLIC HEALTH

## NOTICE OF ADOPTED AMENDMENT

TITLE 77: PUBLIC HEALTH  
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH  
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

## PART 527

## PHYSICAL FITNESS FACILITY MEDICAL EMERGENCY PREPAREDNESS CODE

## Section

527.100	Definitions
527.200	Incorporated and Referenced Materials
527.300	Physical Fitness Facility
527.400	Medical Emergency Plan
527.500	Coordination with Local Emergency Medical Services Systems
527.600	Automated External Defibrillators Required
527.700	Maintenance and Testing of Automated External Defibrillators
527.800	Training
527.900	Complaints and Inspections
527.1000	Violations
527.1100	Hearings

AUTHORITY: Implementing and authorized by the Physical Fitness Facility Medical Emergency Preparedness Act [210 ILCS 74].

SOURCE: Adopted at 29 Ill. Reg. 13855, effective August 23, 2005; amended at 34 Ill. Reg. 11419, effective July 21, 2010; amended at 35 Ill. Reg. 7708, effective April 27, 2011.

**Section 527.600 Automated External Defibrillators Required**

- a) By the compliance dates specified in Section 50 of the Act, each facility shall have at least one ~~operable~~operational AED on the premises at all times.
- b) If the AED becomes inoperable, the facility shall replace or repair the AED within 30 days. The AED shall be mobile and accessible at all times when the AED is operable.
- c) *In the case of an outdoor physical fitness facility, the AED must be housed in a building, if any, that is within 300 feet of the outdoor facility where an event or activity is being conducted. If there is such a building within the required distance, the building must provide unimpeded and open access to the housed*

## DEPARTMENT OF PUBLIC HEALTH

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*AED during the time the event or activity is being conducted. The building's entrances shall further provide marked directions to the housed AED.~~The building's entrances shall provide marked directions to the housed AED. If there is no such building, the person responsible for supervising the event or activity at the outdoor physical fitness facility shall ensure that an AED is available at the outdoor facility during the time that the event or activity at the facility is being conducted.~~ (Section 15(b-10) of the Act)*

- d) *Facilities described in paragraph (1.5) of Section 5.25 of the Act must have an AED on site as well as a trained AED user available only during activities or events sponsored and conducted or supervised by a person or persons employed by the unit of local government, school, college, or university. (Section 5.25 of the Act)*
- e) If multiple facilities are located on the same floor of a building, one AED can be used for multiple facilities so long as the AED is located not more than 300 feet from each facility and access to the AED is unimpeded from each facility.
- f) Facility owners/operators may enter into written contracts with third party operators to ensure that a proper number of AEDs and trained AED users are present during all third party sponsored activities that are not otherwise supervised by the owners/operators of the facility.
- g) Questions concerning this Part shall be directed to the following address:  

Illinois Department of Public Health  
Division of EMS & Highway Safety  
422 S. 5<sup>th</sup> St. – 3<sup>rd</sup> Floor  
Springfield IL 62701
- h) Entities requesting a formal Department determination on the application of the Act shall be subject to inspection under Section 527.900.

(Source: Amended at 35 Ill. Reg. 7708, effective April 27, 2011)

## SECRETARY OF STATE

## NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Public Information, Rulemaking and Organization
- 2) Code Citation: 2 Ill. Adm. Code 550
- 3) Section Number: 550.210                      Adopted Action:  
Amendment
- 4) Statutory Authority: Implementing and authorized by Section 10 of the Secretary of State Merit Employment Code [15 ILCS 310/10], Section 14 of the Secretary of State Act [15 ILCS 305/14], and Section 11 of the Lobbyist Registration Act [25 ILCS 170/11]
- 5) Effective Date of Amendment: April 27, 2011
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Amendment Published in the Illinois Register: None, this is a required rulemaking. These organizational rules were adopted under Section 5-15 of the Illinois Administrative Procedure Act [5 ILCS 100/5-15] and may become effective immediately upon filing as required of this agency under the cited statute for public informational purposes.
- 10) Has JCAR issued a Statement of Objection to this rulemaking? None, this is a required rulemaking. JCAR has not yet reviewed the amendment.
- 11) Differences between proposal and final version: None, this is a required rulemaking.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? None, this is a required rulemaking.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No

SECRETARY OF STATE

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15) Summary and Purpose of Amendment: The intent of this amendatory rulemaking is to update only organizational information as to the statutory additions to the Inspector General's Office of the Secretary of State.

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

Paul Thompson  
Illinois Secretary of State  
Office of the Inspector General  
324 West Monroe Street  
Springfield, Illinois 62704

217/785-2012

17) Does this amendment require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 500/5-25]? No

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

## SECRETARY OF STATE

## NOTICE OF ADOPTED AMENDMENT

TITLE 2: GOVERNMENTAL ORGANIZATION  
SUBTITLE C: CONSTITUTIONAL OFFICERS  
CHAPTER III: SECRETARY OF STATEPART 550  
PUBLIC INFORMATION, RULEMAKING AND ORGANIZATION

## SUBPART A: PUBLIC INFORMATION

Section  
550.10           Public Information

## SUBPART B: RULEMAKING PROCEDURES

Section  
550.110         Rulemaking Procedures

## SUBPART C: ORGANIZATION STRUCTURE

Section  
550.210         Description of Officers and Departments

550.TABLE A     Organization Chart  
550.TABLE B     Rulemaking Chart

AUTHORITY: Implementing and authorized by Section 10 of the Secretary of State Merit Employment Code [15 ILCS 310/10], Section 14 of the Secretary of State Act [15 ILCS 305/14], and Section 11 of the Lobbyist Registration Act [25 ILCS 170/11].

SOURCE: Amended at 2 Ill. Reg. 27, p. 99, effective July 7, 1978; amended at 2 Ill. Reg. 43, p. 185, effective October 18, 1978; new rules adopted at 2 Ill. Reg. 51, p. 31, effective December 11, 1978; old rules repealed at 3 Ill. Reg. 6, p. 61, effective January 31, 1979; old rules repealed, new rules adopted and codified at 7 Ill. Reg. 12878, effective September 16, 1983; amended at 7 Ill. Reg. 15883, effective November 9, 1983; amended at 8 Ill. Reg. 5356, effective April 4, 1984; amended at 11 Ill. Reg. 14824, effective September 25, 1987; amended at 12 Ill. Reg. 7726, effective April 15, 1988; amended at 12 Ill. Reg. 17969, effective November 1, 1988; amended at 16 Ill. Reg. 7697, effective May 4, 1992; amended at 17 Ill. Reg. 9986, effective June 22, 1993; amended at 32 Ill. Reg. 15282, effective November 5, 2007; amended at 35 Ill. Reg. 7712, effective April 27, 2011.

## SECRETARY OF STATE

## NOTICE OF ADOPTED AMENDMENT

## SUBPART C: ORGANIZATION STRUCTURE

**Section 550.210 Description of Officers and Departments**

- a) The Deputy Secretary of State is responsible for the daily operations of the Office of the Secretary of State, which includes the management of all employees and the oversight of all programs and policies.
- b) The Chief of Staff is responsible for providing oversight and ~~policy~~-program policy direction to all cabinet members and executive staff, and advises the Secretary of State, in concert with other specified officials.
- c) The General Counsel to the Secretary advises the Secretary, Deputy Secretary, Chief of Staff, and other management officials on legal questions of broad applicability, supervises all litigation involving the Secretary of State, ~~and~~ coordinates that litigation with the Attorney General's Office and U.S. Attorney's Office, and provides oversight of related departments within the Office of the Secretary of State.
- d) The Inspector General Department:
  - 1) investigates all allegations of wrongdoing involving personnel of the Office of the Secretary of State and presents reports on its findings to the Secretary, Deputy Secretary, Chief of Staff, and appropriate Directors for possible disciplinary action; ~~and~~
  - 2) through its Internal Audit Division, conducts fiscal and compliance audits of Secretary of State operations; ~~and-~~
  - 3) investigates alleged violations of the Lobbyist Registration Act [25 ILCS 170].
- e) The Chief Auditor is responsible for all investigatory and compliance audits and reports findings of these audits to the Secretary.
- f) The Press Secretary is responsible for handling inquiries from the press, preparing press releases, and the printing of all office publications.
- g) The Deputy Chief of Staff is responsible for the development and implementation of plans and programs that affect several departments, as determined by the

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Secretary, Deputy Secretary, or Chief of Staff.

- h) The Executive Assistant for Programs and Policy assists the Deputy Chief of Staff with the formulation of new and continuing programs from their inception and is responsible for development of those programs by the Program Staff.
- i) The Program Staff assists the Executive Assistant for Programs and Policies with the development of ideas and implementation of goals as determined by the Secretary, Deputy Secretary, or Deputy Chief of Staff.
- j) The Budget and Fiscal Management Department prepares the annual budget, monitors expenditures of all funds appropriated to the Secretary of State, and prepares the payroll for the Office of the Secretary of State.
- k) The Department of Information Technology directs, manages, and supervises data processing operations for the Secretary of State.
- l) The Accounting Revenue Department collects all funds [received by the Office of the Secretary of State](#) for deposit with the State Treasurer ~~received by the Office of the Secretary of State~~, directs the financial institutions' sales program for vehicle registrations, and performs audits pursuant to the Illinois Vehicle Code.
- m) The Physical Services Department is responsible for the physical maintenance of the Michael J. Howlett Building, the Capitol Building, the Stratton Building, and the surrounding grounds, and has responsibility for other government buildings, as provided by law.
- n) The Personnel Department processes all applications for employment with the Office of the Secretary of State, administers all tests for employment, and approves all personnel actions taken pursuant to the Secretary of State Merit Employment Code [15 ILCS 310].
- o) The Communications Department is responsible for answering all media inquiries concerning the Office of the Secretary of State and preparation and coordination of all public displays and publications relating to the Office of the Secretary of State.
- p) The Department of Police's officers have general police powers. The Department's special emphasis is in enforcement of the Illinois Vehicle Code, including investigation of auto theft and regulation of the trucking industry.

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- q) The Index Department is the custodian of the State Seal, receives all bills signed into law by the Governor, maintains the Illinois Administrative Code, maintains all notary public commissions and ethics statements, maintains lobbyist registrations and expenditure reports and prepares all Constitutional Amendments for the ballot.
- r) The Archives Department maintains all State records and documents required to be kept by law.
- s) The Illinois State Library is the central research library for Illinois government.
- t) The Driver Services Department issues, revokes, or suspends all Illinois driver's licenses and also issues photo identification cards.
- u) The Vehicle Services Department issues all license plates and licenses remittance agents, automobile dealers and recyclers.
- v) The Legislative Affairs Department coordinates the legislative program of the Secretary of State.
- w) The Administrative Hearings Department conducts all hearings pursuant to the Illinois Vehicle Code [625 ILCS 5/2-118].
- x) The Business Services Department administers the Business Corporation Act of 1983 [805 ILCS 5], Article 9 of the Uniform Commercial Code (Secured Transaction) [810 ILCS 5], such other corporate statutes as designated by the General Assembly, and the Revised Uniform Limited Partnership Act [805 ILCS 210].
- y) The Securities Department administers the Illinois Securities Law of 1953 [815 ILCS 5].
- z) The Court of Claims Department exercises the duties of the Secretary of State as Clerk of the Court of Claims.
- aa) The Director for Intergovernmental Affairs coordinates the interaction between the Secretary of State's Office and units of local, state, and federal government. The Director for Intergovernmental Affairs also coordinates the constituent service and program implementation work of the Office of the Secretary of State.

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- bb) Senior Executive Assistants coordinate efforts between assigned departments and the Executive Office and assist with operations and development of policies and programs with respect to their assigned departments.

(Source: Amended at 35 Ill. Reg. 7712, effective April 27, 2011)

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

- 1) Heading of the Part: Medicaid Community Mental Health Services Program
- 2) Code Citation: 59 Ill. Adm. Code 132
- 3) 

<u>Section Numbers</u> :	<u>Emergency Action</u> :
132.25	Repeal
132.58	Repeal
132.95	Repeal
132.145	Repeal
- 4) Statutory Authority: Implementing and authorized by the Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3]
- 5) Effective Date of Repeal of Emergency Amendments: April 28, 2011
- 6) If this emergency repeal of emergency amendments is to expire before the end of the 150-day period, please specify the date on which it is to expire: This emergency repeal of emergency amendment will expire on May 30, 2011.
- 7) Date filed with the Index Department: April 28, 2011
- 8) A copy of the emergency repeal of emergency amendments, including any material incorporated by reference, is on file with the agency's principal office and is available for public inspection.
- 9) Reasons for Emergency: The emergency repeal of emergency amendments is in response to the Joint Committee on Administrative Rules Objection that indicated that DHS' new utilization management policy presented a potential threat to the public safety, interest and welfare of adolescent patients receiving treatment programs under Medicaid.
- 10) A Complete Description of the Subjects and Issues Involved: This emergency repeal of emergency amendments removes all language in Sections 132.25, 132.58, 132.95 and 132.145 that was added as a result of the emergency rule that was effective January 1, 2011.
- 11) Are there any proposed amendments to this Part pending? Yes

Section Numbers:      Proposed Action:      Illinois Register Citation:

## DEPARTMENT OF HUMAN SERVICES

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132.25	Amendment	35 Ill. Reg. 709; January 14, 2011
132.58	Amendment	35 Ill. Reg. 709; January 14, 2011
132.95	Amendment	35 Ill. Reg. 709; January 14, 2011
132.145	Amendment	35 Ill. Reg. 709; January 14, 2011

- 12) Statement of Statewide Policy Objectives: To clearly indicate to the public and providers that the utilization management program has ceased.
- 13) Information and questions regarding this emergency repeal of emergency amendments shall be directed to:

Tracie Drew, Chief  
Bureau of Administrative Rules and Procedures  
Department of Human Services  
100 South Grand Avenue East  
Harris Building, 3<sup>rd</sup> Floor  
Springfield, Illinois 62762

217/785-9772

The full text of the Emergency Repeal of Emergency Amendments begin on the next page:

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## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

TITLE 59: MENTAL HEALTH  
CHAPTER IV: DEPARTMENT OF HUMAN SERVICESPART 132  
MEDICAID COMMUNITY MENTAL  
HEALTH SERVICES PROGRAM

## SUBPART A: GENERAL PROVISIONS

## Section

132.10	Purpose
132.15	Incorporation by Reference
132.20	Clients' Rights and Confidentiality (Repealed)
132.25	Definitions
<a href="#">EMERGENCY</a>	
132.30	Application, Certification and Recertification Processes
132.35	Recertification and Reviews (Repealed)
132.40	Certification for Additional Medicaid Community Mental Health Services and/or New Site(s) (Repealed)
132.42	Post-Payment Review
132.44	Appeal of Post-Payment Review Findings
132.45	Compliance with Certification Requirements
132.50	Revocation of Certification
132.55	Appeal of Certification Decisions
<a href="#">132.58</a>	<a href="#">Utilization Management by the Public Payer</a>
<a href="#">EMERGENCY</a>	
132.60	Rate Setting

## SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

## Section

132.65	Organizational Requirements
132.70	Personnel and Administrative Recordkeeping
132.75	Program Evaluation (Repealed)
132.80	Fiscal Requirements
132.85	Recordkeeping
132.90	Provider Sites
132.91	Accreditation
132.95	Utilization Review

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- 132.100 Clinical Records
- 132.105 Continuity and Coordination of Services (Repealed)
- 132.110 Availability of Services (Repealed)
- 132.115 Provisions (Repealed)
- 132.120 Service Needs Evaluation (Repealed)
- 132.125 Treatment Plan Development and Modification (Repealed)
- 132.130 Psychiatric Treatment (Repealed)
- 132.135 Crisis Intervention (Repealed)
- 132.140 Day Treatment

## SUBPART C: MENTAL HEALTH SERVICES

## Section

- 132.142 Clients' Rights
- 132.145 General Provisions

EMERGENCY

- 132.148 Evaluation and Planning
- 132.150 Mental Health Services
- 132.155 Family Intervention, Stabilization and Reunification Services (Repealed)
- 132.160 Provisions (Repealed)
- 132.165 Mental Health Case Management Services
- 132.170 Rehabilitative Case Management Services (Repealed)

132.APPENDIX A Medicaid Community Mental Health Services Application Components (Repealed)

132.APPENDIX B Utilization Parameters (Repealed)

132.TABLE A Mental Health Clinic Program Client Services (Repealed)

132.TABLE B Rehabilitative Mental Health Services (Repealed)

132.TABLE C Family Intervention, Stabilization and Reunification Services (Repealed)

**AUTHORITY:** Implementing and authorized by the Community Services Act [405 ILCS 30] and Section 15.3 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705/15.3].

**SOURCE:** Emergency rules adopted at 16 Ill. Reg. 211, effective December 31, 1991, for a maximum of 150 days; new rules adopted at 16 Ill. Reg. 9006, effective May 29, 1992; amended at 18 Ill. Reg. 15593, effective October 5, 1994; emergency amendment at 19 Ill. Reg. 9200,

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effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16178, effective November 28, 1995; amended at 21 Ill. Reg. 8292, effective June 25, 1997; recodified from the Department of Mental Health and Developmental Disabilities to the Department of Human Services at 21 Ill. Reg. 9321; amended at 22 Ill. Reg. 21870, effective December 1, 1998; emergency amendment at 23 Ill. Reg. 4497, effective April 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 10205, effective August 23, 1999; amended at 24 Ill. Reg. 17737, effective November 27, 2000; amended at 26 Ill. Reg. 13213, effective August 20, 2002; amended at 28 Ill. Reg. 11723, effective August 1, 2004; amended at 31 Ill. Reg. 9097, effective July 1, 2007; emergency amendments at 31 Ill. Reg. 10159, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 15805, effective November 8, 2007; amended at 32 Ill. Reg. 9981, effective July 1, 2008; emergency amendment at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011, for the remainder of the 150 days.

## SUBPART A: GENERAL PROVISIONS

**Section 132.25 Definitions****EMERGENCY**

For the purposes of this Part, the following terms are defined:

**Admission Note** – A written report of an initial assessment and treatment plan that initiates Rule 132 services for clients who are admitted to a specialized substitute care living arrangement or for the client who does not have a completed mental health assessment and is admitted to ACT services or a residential facility designated by the public payer for the purpose of stabilizing a crisis.

**Adult** – An individual who is 18 years of age or older or a person who is emancipated pursuant to the Emancipation of Mature Minors Act [750 ILCS 30].

**Applicant** – An entity that seeks certification to provide Medicaid community mental health services under this Part.

**Certified Recovery Support Specialist or CRSS** – An individual who is certified and in good standing as a Recovery Support Specialist by the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. (IAODAPCA).

**Certifying State Agency** – Departments responsible for determining and monitoring compliance with this Part: Department of Healthcare and Family

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Services, Department of Human Services, Department of Children and Family Services or the Department of Corrections.

CGAS – The Children's Global Assessment Scale as published in the Archives of General Psychiatry, Volume 40, November 1983, pp. 1228-1231.

Client – An individual who is Medicaid-eligible and is receiving Medicaid community mental health services.

CMMS – Centers for Medicare and Medicaid Services. A federal agency within the U.S. Department of Health and Human Services with responsibility for Medicare, Medicaid, State Children's Health Insurance (SCHIP), Health Insurance Portability and Accountability Act (HIPAA), and Clinical Laboratory Improvement Amendments (CLIA).

Collateral – A person with a relationship to a client and who is important in the treatment or recovery goals of the client or who is a resource to assist the client in meeting treatment or recovery goals.

Confidentiality Act – The Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

Contract – For purposes of this Part, a written agreement between the applicant/provider and a public payer.

Co-occurring – Co-existing mental health and substance use disorders or developmental disabilities. Individuals eligible to receive services under this Part must have a diagnosis of mental illness.

Day – A calendar day unless otherwise indicated.

DCFS – The Illinois Department of Children and Family Services.

DHS – The Illinois Department of Human Services.

DOC – The Illinois Department of Corrections.

DSM-IV – The Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition (1994) or DSM-IV-TR (2000), American Psychiatric Association, 1000 Wilson

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Boulevard, Suite 1825, Arlington, Virginia 22209-3901.

Enrollment – The official enrollment of a provider in the medical assistance program by HFS on determination of compliance with 89 Ill. Adm. Code 140.11.

Family – A basic unit or constellation of one or more adults and children, foster or adoptive parents and children, and private individual guardians.

Family Resource Developer – A parent or care-giver who has navigated multiple child serving systems on behalf of a child or adolescent with Severe Emotional Disturbance (SED) as a consumer of the mental health system. The individual has a high school diploma or equivalency and has demonstrated the ability to work collaboratively with families, children, agency staff and other providers in the community.

GAF – The Global Assessment of Functioning Scale contained in the DSM-IV.

Guardian – The court-appointed guardian or conservator of the person under the Probate Act of 1975 [755 ILCS 5] or a temporary custodian or guardian of the person of a child appointed by an Illinois juvenile court or a legally-appointed guardian or custodian or other party granted legal care, custody and control over a minor child by a juvenile court of competent jurisdiction located in another state whose jurisdiction has been extended into Illinois via the child's legally authorized placement in accordance with the applicable interstate compact. (The Juvenile Court Act of 1987 [705 ILCS 405]; Interstate Compact on the Placement of Children [45 ILCS 15])

HFS – The Illinois Department of Healthcare and Family Services.

HIPAA – The Health Insurance Portability and Accountability Act (42 USC 1320 et seq.) (45 CFR 160 and 164 (2003)).

ICD-9-CM – International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 (2008)).

ITP – Individual treatment plan.

Level of Role Functioning – Refers to the client's abilities in critical areas such as

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vocational, educational, independent living, self-care, and social and family relationships. To assess the severity of the impairment in role functioning, scales approved for use include, but are not limited to, the GAF Scale or the CGAS Scale.

Licensed Clinician – An individual who is either a licensed practitioner of the healing arts (LPHA); a licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least two years experience in mental health services; a licensed professional counselor (LPC) possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services; a registered nurse (RN) licensed under the Nurse Practice Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing; or an occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting.

Licensed Practitioner of the Healing Arts or LPHA – An Illinois licensed health care practitioner who, within the scope of State law, has the ability to independently make a clinical assessment, certify a diagnosis and recommend treatment for persons with a mental illness and who is one of the following: a physician; an advanced practice nurse with psychiatric specialty licensed under the Nurse Practice Act [225 ILCS 65]; a clinical psychologist licensed under the Clinical Psychologist Licensing Act [225 ILCS 15]; a licensed clinical social worker (LCSW) licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20]; a licensed clinical professional counselor (LCPC) licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or a licensed marriage and family therapist (LMFT) licensed under the Marriage and Family Therapist Licensing Act [225 ILCS 55] and 68 Ill. Adm. Code 1283.

Medicaid – Medical assistance authorized by HFS under the provisions of the Illinois Public Aid Code [305 ILCS 5/Art. V], the Children's Health Insurance Program Act [215 ILCS 106] and Titles XIX and XXI of the Social Security Act (42 USCA 1396 and 1397aa).

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Medical Necessity or Medically Necessary – A mental health intervention is medically necessary if:~~A LPHA has determined through diagnosis and assessment that a client:~~

the individual has a diagnosis of mental illness or serious emotional disorder as defined in ~~the~~ ICD-9-CM or DSM-IV ~~that has resulted in a significant deterioration in the client's level of role functioning in critical life areas; and~~

needs each prescribed mental health services a service identified as appropriate to the individual's needs as identified in a mental health assessment; and in the Mental Health Assessment and Individual Treatment Plan to stabilize the client's role functioning or to restore the client to a maximum level of role functioning.

the intervention could not have been omitted without adversely affecting the individual's functioning.

The LPHA shall recommend that medical or remedial services are necessary to reduce the physical or mental disability of an individual and to restore an individual to the maximum possible functioning level. A service under this Part is not medically necessary if it is provided solely for the convenience of the individual, his or her family or the provider ~~or exceeds in scope, duration, or intensity the level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment.~~

Mental Health Professional or MHP – An individual who provides services under the supervision of a qualified mental health professional and who possesses: a bachelor's degree; a practical nurse license under the Nurse Practice Act [225 ILCS 65]; a certificate of psychiatric rehabilitation from a DHS-approved program plus a high school diploma plus 2 years experience in providing mental health services; a recovery support specialist certified and in good standing with the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc., plus one year experience in providing mental health services; an occupational therapy assistant licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of experience in a mental health setting; or a minimum of 5 years supervised experience in mental health or human services. A supervised internship in a mental health setting counts toward the experience in providing mental health services. Any individual meeting the

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minimum credentials for an LPHA or QMHP under this Part is deemed to also meet the credentialing requirements of an MHP.

**Mental Illness** – A mental or emotional disorder diagnosis contained in the DSM-IV or ICD-9-CM, authorized by the public payer funding the services under this Part and the condition that will be the main focus of treatment for services under this Part. Mental illness does not include organic disorders such as dementia and those associated with known or unknown physical conditions such as hallucinosis, amnestic disorder and delirium; psychoactive substance induced organic mental disorders; and mental retardation or psychoactive substance use disorders.

**Natural Setting** – A setting where an individual not identified as mentally ill typically spends time, including home, school, work, churches, community centers, libraries, parks, recreation centers, etc. These sites are not licensed, certified or accredited as a treatment setting nor typically identified as treatment sites.

**Off-site** – Locations other than a certified provider site as described in Section 132.90. A place of residence that is owned or leased by a provider and occupied by a client also will be considered off-site unless there is a certified site connected to the residence.

**On-site** – Location that is a certified provider site as described in Section 132.90.

**Part 132 Services** – The community mental health services described in this Part.

**Physician** – A physician licensed under the Medical Practice Act of 1987 [225 ILCS 60] to practice medicine in all its branches.

**Provider** – An entity certified to provide Medicaid community mental health services in accordance with this Part.

**Public Payer** – HFS, a State agency or a unit of local government that is responsible for payment for services under this Part provided to a client pursuant to a contract with the provider.

**Qualified Mental Health Professional or QMHP** – One of the following:

A licensed social worker (LSW) possessing at least a master's degree in

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social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least 2 years experience in mental health services;

A licensed professional counselor possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with specialized training in mental health services or with at least two years experience in mental health services;

A registered nurse (RN) licensed under the Nurse Practice Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing;

An occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting; or

An individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service, or who has one year of clinical experience under the supervision of a QMHP.

Any individual meeting the minimum credentials for [an](#) LPHA under this part is deemed to also meet the credentialing requirements of a QMHP.

Rehabilitative Services Associate or RSA – An RSA must be at least 21 years of age, have demonstrated skills in the field of services to adults or children, have demonstrated the ability to work within the provider's structure and accept supervision, and have demonstrated the ability to work constructively with clients, treatment resources and the community. Any individual meeting the minimum credentials for an MHP, QMHP or LPHA under this Part is deemed to also meet the credentialing requirements of an RSA.

SASS – A program of intensive mental health services provided by an agency certified to provide Part 132 services and under contract to provide screening,

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assessment and support services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.

Specialized Substitute Living Arrangement – A living arrangement providing services to a client supervised by a provider licensed under the Child Care Act of 1969 [225 ILCS 10] or any comparable Act in another state when the provider is under contract to the State agency.

State Agency – Department of Healthcare and Family Services, Department of Juvenile Justice, Department of Human Services, Department of Children and Family Services or the Department of Corrections.

Unit of Local Government – A county, municipal corporation, or other local government entity organized under the laws of the State of Illinois that, pursuant to an executed intergovernmental agreement with HFS, has agreed to pay for Medicaid community mental health services.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011, for the remainder of the 150 days)

~~Section 132.58 – Utilization Management by the Public Payer~~  
EMERGENCY

- a) ~~The recommendation by the provider's LPHA using the standards in Section 132.145 for determining medical necessity may be reviewed by a LPHA employed by the public payer, or a LPHA designee to confirm ongoing medical necessity for each prescribed service in each client record selected for review after the initiation of services. The public payer shall notify the provider of the findings of the medical necessity review within 7 days of the end of the review.~~
- b) ~~If there is a finding in the review that ongoing medical necessity is not demonstrated, the public payer may not pay for any service it determines is not medically necessary unless a request for reconsideration or an appeal is filed.~~
- e) ~~If the public payer and the LPHA of the provider do not concur on medical necessity, the provider may request reconsideration of the decision of the public payer in writing within 30 days of the review to the public payer specifying the~~

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~~grounds for the reconsideration. The provider may submit additional supporting evidence or documentation for the reconsideration. During the reconsideration, the client may continue to receive service that will be funded by the public payer.~~

- ~~1) The reconsideration request shall be reviewed by a LPHA, designated by the public payer, who has not been involved in the above finding within 14 days of receipt of the reconsideration request.~~
- ~~2) If the LPHA denies the reconsideration request of the provider, the provider may appeal in writing within 5 days of the date of the denial to the director/secretary of the public payer. No additional evidence or documentation may be provided for the appeal.~~
- ~~3) The appeal provisions in Section 132.44 are not applicable to appeals under this Section.~~
- ~~4) The director/secretary shall issue a final administrative decision regarding the appeal.~~
- ~~5) The final administrative decision shall be subject to judicial review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art. III].~~
- ~~d) If an appeal is filed, the client may continue to receive service that will be funded by the public payer during the appeal process.~~
- ~~e) If the finding of the final appeal agrees that the service is not medically necessary, the provider must inform the client of the finding and work with the client to make an informed choice about continuing the service with non-public payer funding or receiving a different medically necessary Part 132 service.~~

(Source: Added by emergency rulemaking at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011, for the remainder of the 150 days)

## SUBPART B: PROVIDER ADMINISTRATIVE REQUIREMENTS

**Section 132.95 Utilization Review****EMERGENCY**

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The provider shall have a written utilization review (UR) plan and ongoing activities to assess assessment of the appropriateness of medical necessity of Medicaid community mental health services, including the intensity/level of services, and continued services need for each service for the client. Such services may be subject to utilization management parameters established by the public payer. These parameters may include, but not be limited to, the volume of service delivered to a single client over a fixed period of time or significant changes in volume of service billed by a specific provider. The written UR plan shall address:

- a) ~~A review of medical necessity or that services are medically necessary as determined by:~~
  - 1) ~~The definition of medical necessity in this Part;~~
  - 2) ~~The type, severity and chronicity of the client's symptoms;~~
  - 3) ~~The severity of impairment in the client's role functioning;~~
  - 4) ~~The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts;~~
  - 5) ~~The expected short-term and long-term outcome of each service needed by the client;~~
  - 6) ~~Progress made in response to treatment, if the client is currently receiving treatment; and~~
  - 7) ~~Criteria or guidance published by the public payer for the purposes of defining and evaluating the medical necessity of each service;~~
- b) The methods and procedures for performing and recording individual case reviews by persons not involved in providing services to the clients whose records are reviewed;
- be) The authority and functions of the individual case review designated unit, which may be:
  - 1) A representative committee, chaired by a QMHP, and including QMHPs, MHPs, and RSAs; or

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2) A QMHP;

- ~~cd)~~ Procedures describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 percent of the clients served under this Part annually;
- ~~de)~~ Procedures to ensure that the review includes and summarizes the client's progress over the previous 90 days;
- ~~f)~~ ~~Procedures to ensure that the review includes and summarizes the client's involvement in service planning and provision over the previous 90 days;~~
- ~~eg)~~ Policies and procedures for documenting and reporting individual case reviews findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department;
- ~~fh)~~ Procedures for appeal by clients and staff affected by the UR decisions with which they disagree;
- ~~gi)~~ Provisions for ensuring confidentiality of individual case reviews, determinations, results and/or recommendations in accordance with the Confidentiality Act and HIPAA; and
- ~~hj)~~ Procedures for following up on case review recommendations.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011, for the remainder of the 150 days)

## SUBPART C: MENTAL HEALTH SERVICES

**Section 132.145 General Provisions****EMERGENCY**

A provider shall comply with the following:

- a) A provider shall, at a minimum, directly provide mental health assessment, ITP

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development, review, modification (see Section 132.148(c)) and at least one additional Part 132 mental health service. Directly provided means that the QMHP and LPHA who signed the mental health assessment and ITP are employed by or contractual employees of the provider. The public payer may waive the requirement of at least one additional Part 132 mental health service if it deems that such waiver increases the availability of mental health services to Medicaid-eligible clients.

- b) A provider may subcontract for services authorized by this Part. All subcontractors must be certified to participate in the Illinois Medical Assistance program and enrolled as a provider with HFS. There shall be a written agreement between the provider and the subcontractor that defines their contractual agreement and assures the subcontractor's compliance with applicable service provisions of Subpart C. All subcontracts must be approved by and on file with the State agency and, when applicable, the public payer. For purposes of this subsection, a contractual employee or an individual on contract is not considered to be a subcontractor.
- c) Unless specified otherwise, services under this Part shall be provided to clients with a diagnosis of mental illness as defined in Section 132.25 and whose level of role functioning, in the absence of treatment or medication, is impaired. The provision of mental health services is expected to result in an improvement or prevention of regression in the client's existing condition.
- d) Consent
  - 1) Prior to the initiation of mental health services, the provider shall obtain written or oral consent from the client and the client's parent or guardian, as applicable.
  - 2) Consent must be given by the parent or guardian for a child under 12 years of age, except a child 12 through 17 years of age can consent to treatment for 5 outpatient sessions of no more than 45 minutes in duration.
  - 3) If the client is determined to be in need of crisis intervention services, or if the assessment is court ordered for the client, consent is not required.
  - 4) Legally competent adults who participate in treatment services are deemed to have consented.

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- 5) Oral consent shall also be documented in the record.
- e) ~~An~~ LPHA shall provide the clinical direction and recommend medically necessary services as documented by his or her dated ~~original~~ signature ~~with credentials~~ on the mental health assessment and ITP. ~~In determining whether there is medical necessity for each service under this Part, the LPHA shall consider and document that consideration among other factors:~~
- 1) ~~The definition of medical necessity in this Part;~~
  - 2) ~~The type, severity and chronicity of the client's symptoms;~~
  - 3) ~~The severity of impairment in the client's role functioning;~~
  - 4) ~~The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts;~~
  - 5) ~~The expected short-term and long-term outcome of each service needed by the client;~~
  - 6) ~~Progress made in response to treatment, if the client is currently receiving treatment; and~~
  - 7) ~~Criteria or guidance published by the public payer for the purposes of defining and evaluating the medical necessity of each service.~~

The public payer, or his or her designee, may provide additional clinical direction in determining whether services are medically necessary. If the public payer or its designee and the LPHA do not concur on medical necessity, an appeal may be initiated in writing or by phone in accordance with the Service Authorization Protocol located on the DHS website at <http://www.dhs.state.il.us/page.aspx?item=33244>.

- f) When discharging a client from services, the provider shall ensure the continuity and coordination of services as provided in the client's ITP. The provider shall:
- 1) Communicate, consistent with the requirements of Section 132.142, relevant treatment and service information prior to or at the time that the

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client is transferred to a receiving program of the provider or is terminated from service and referred to a program operated by another service provider, if the client, or parent or guardian, as appropriate, provides written authorization; and

- 2) Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services.
- g) Services provided under this Part are subject to the provisions of an executed contract between the provider and the public payer. The public payer is not required to reimburse services under this Part not enumerated in the contract.

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1128, effective January 1, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7719, effective April 28, 2011, for the remainder of the 150 days)

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- 1) Heading of the Part: Award and Monitoring of Funds
- 2) Code Citation: 77 Ill. Adm. Code 2030
- 3) 

<u>Section Numbers:</u>	<u>Emergency Action:</u>
2030.20	Repeal
2030.105	Repeal
2030.107	Repeal
2030.108	Repeal
2030.109	Repeal
- 4) Statutory Authority: Authorized by the Illinois Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301]
- 5) Effective Date of Repeal of Emergency Amendments: April 28, 2011
- 6) If this emergency repeal of emergency amendments is to expire before the end of the 150-day period, please specify the date on which it is to expire: This emergency repeal of emergency amendments will expire June 5, 2011.
- 7) Date filed with the Index Department: April 28, 2011
- 8) A copy of the emergency repeal of emergency amendments, including any material incorporated by reference, is on file with the agency's principal office and is available for public inspection.
- 9) Reasons for Emergency: The emergency repeal of emergency amendments is in response to the Joint Committee on Administrative Rules Objection that indicated that DHS' new utilization management policy presented a potential threat to the public safety, interest and welfare of adolescent patients receiving treatment programs under Medicaid.
- 10) A Complete Description of the Subjects and Issues Involved: This emergency repeal of emergency amendments removes all language in Sections 2030.20, 2030.105, 2030.107, 2030.108, and 2030.109 that was added as a result of the emergency rule that was effective January 7, 2011.
- 11) Are there any proposed amendments to this Part pending? Yes

Section Numbers:      Proposed Action:      Illinois Register Citation:

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2030.20	Amendment	35 Ill. Reg. 1327; January 21, 2011
2030.105	Amendment	35 Ill. Reg. 1327; January 21, 2011
2030.107	Amendment	35 Ill. Reg. 1327; January 21, 2011
2030.108	Amendment	35 Ill. Reg. 1327; January 21, 2011
2030.109	Amendment	35 Ill. Reg. 1327; January 21, 2011

- 12) Statement of Statewide Policy Objectives: To clearly indicate to the public and providers that the utilization management program has ceased.
- 13) Information and questions regarding this emergency repeal of emergency amendments shall be directed to:

Tracie Drew, Chief  
Bureau of Administrative Rules and Procedures  
Department of Human Services  
100 South Grand Avenue East  
Harris Building, 3<sup>rd</sup> Floor  
Springfield, Illinois 62762

217/785-9772

The full text of the Emergency Repeal of Emergency Amendments begin on the next page:

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TITLE 77: PUBLIC HEALTH  
CHAPTER X: DEPARTMENT OF HUMAN SERVICES  
SUBCHAPTER c: ADMINISTRATION OF FUNDINGPART 2030  
AWARD AND MONITORING OF FUNDS

## SUBPART A: GENERAL

## Section

2030.10	Applicability
2030.20	<del>Incorporation by Reference and</del> Definitions
	<u>EMERGENCY</u>
2030.30	Exceptions
2030.40	Special Award Conditions

## SUBPART B: AWARD CRITERIA AND PROCEDURE

## Section

2030.100	Recipient Eligibility
2030.105	Services Eligible for Grant-in-Aid Funding
	<u>EMERGENCY</u>
2030.107	Services Eligible for Purchased-Care or Fee-for-Service Funding
	<u>EMERGENCY</u>
<del>2030.108</del>	<del>Medical Necessity for ASAM Level III.5 Treatment</del>
	<u>EMERGENCY</u>
<del>2030.109</del>	<del>Utilization Management</del>
	<u>EMERGENCY</u>
2030.110	Other Activities for Which Awards May be Made
2030.115	Award Process
2030.120	Department Budget Planning Requirements
2030.130	Provider Plan/Recipient Budget
2030.140	Award Document
2030.150	Subawards
2030.160	Modification or Amendment of the Award Document

SUBPART C: DEPARTMENT APPROVAL FOR PROGRAMMATIC AND BUDGET  
REVISIONS AND FOR COSTS REQUIRING PRIOR APPROVAL

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Section	
2030.210	Process
2030.220	Programmatic Changes
2030.230	Budget Revision

## SUBPART D: COST PRINCIPLES/ALLOWABILITY

Section	
2030.310	Applicability
2030.320	Allowable Costs (Repealed)
2030.330	Approval of Costs
2030.340	Allocation of Costs/Direct and Indirect Costs (Repealed)
2030.350	Costs Allowable with Prior Approval of the Department (Repealed)
2030.360	Unallowable or Limited Costs (Repealed)

## SUBPART E: NON-DEPARTMENTAL FUNDING

Section	
2030.410	Non-Department Funding
2030.420	Record Keeping (Repealed)
2030.430	Program Income
2030.440	Maintenance of Effort
2030.450	Client Fees

## SUBPART F: MATCHING AND COST PARTICIPATION REQUIREMENTS

Section	
2030.510	General
2030.520	Definitions
2030.530	Eligible Costs
2030.540	Criteria for Contributions (Repealed)
2030.550	Valuation of In-Kind Contributions

## SUBPART G: FINANCIAL MANAGEMENT

Section	
2030.610	Accounting and Financial Management Requirements (Repealed)
2030.620	Audit Requirements (Repealed)

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SUBPART H: FINANCIAL REPORTING

Section

- 2030.710 General (Repealed)
- 2030.720 Quarterly Revenue/Expense Reports – Grant-in-Aid Recipients (Repealed)
- 2030.730 Lapsed Grant-in-Aid Funds (Repealed)
- 2030.740 End of the Year Report (Repealed)
- 2030.750 Purchased-Care/Fee-for-Service Invoicing and Auditing
- 2030.760 Exempt Recipients (Repealed)

SUBPART I: MONITORING AND REPORTING OF PROGRAM PERFORMANCE

Section

- 2030.810 Site Visits
- 2030.820 Reports
- 2030.830 Underutilization
- 2030.840 Criminal Justice System Referrals
- 2030.850 Prior Submissions

SUBPART J: FUND DISBURSEMENT

Section

- 2030.910 General

SUBPART K: CLOSEOUT

Section

- 2030.1010 Definitions (Repealed)
- 2030.1020 Unilateral Termination (Repealed)
- 2030.1030 Termination by Agreement (Repealed)
- 2030.1040 Termination or Suspension for Cause (Repealed)
- 2030.1050 Actions on Termination (Repealed)
- 2030.1060 Suspension Process (Repealed)
- 2030.1070 Summary Suspension (Repealed)
- 2030.1080 Termination for Cause Process (Repealed)
- 2030.1090 Closeout

SUBPART L: PROPERTY MANAGEMENT STANDARDS

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## Section

- 2030.1110 Scope (Repealed)
- 2030.1120 Definitions (Repealed)
- 2030.1130 Real Property (Repealed)
- 2030.1140 Non-Expendable Personal Property (Repealed)
- 2030.1150 Expendable Personal Property (Repealed)
- 2030.1160 Copyrights, Patents and Royalties

## SUBPART M: GENERAL PROVISIONS REGARDING AWARD PERFORMANCE

## Section

- 2030.1205 Civil Rights/Nondiscrimination
- 2030.1210 Compliance During Award Period
- 2030.1215 Conflict of Interest (Repealed)
- 2030.1220 Notices
- 2030.1225 Personnel Administration (Repealed)
- 2030.1230 Procurement Standards
- 2030.1235 Personnel Administration
- 2030.1245 Protection of Client Records/Confidentiality
- 2030.1250 Publicity and Publications
- 2030.1255 Retention and Access Requirements for Records
- 2030.1260 Rights in Data
- 2030.1265 Severability
- 2030.1270 Subawards

## SUBPART N: SPECIAL PROVISIONS

## Section

- 2030.1310 Special Provisions for Purchase of Medical Services
- 2030.1320 Special Provisions for Prevention Services

AUTHORITY: Authorized by the Illinois Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301].

SOURCE: Old Part repealed, new Part adopted at 16 Ill. Reg. 2457, effective February 4, 1992; recodified from Department of Alcoholism and Substance Abuse to Department of Human Services at 21 Ill. Reg. 9319; emergency amendment at 22 Ill. Reg. 12158, effective June 24, 1998, for a maximum of 150 days; emergency expired November 20, 1998; amended at 23 Ill. Reg. 488, effective December 28, 1998; emergency amendment at 24 Ill. Reg. 9211, effective

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June 14, 2000, for a maximum of 150 days; emergency expired November 10, 2000; amended at 24 Ill. Reg. 18099, effective November 30, 2000; emergency amendment at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days.

## SUBPART A: GENERAL

**Section 2030.20 Definitions****EMERGENCY**

The following definitions shall apply to this Part:

"Act" means the Illinois Alcoholism and Other Drug Dependency Act [20 ILCS 301].

~~"Administrative Review Law" 735 ILCS 5/Art.III] means the State law that provides an individual with the right to judicial review of a Final Administrative Decision.~~

~~"ASAM" means the American Society of Addiction Medicine.~~

~~"ASAM Patient Placement Criteria" means the American Society of Addiction Medicines Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAMPPC 2R), 4601 North Park Avenue, Upper Arcade Suite 101, Chevy Chase MD 20815, (2001, no later amendment or editions included) or <http://www.asam.org/PatientPlacementCriteria.html>.~~

"Award" means financial assistance in the form of money, property or services in lieu of money, by the Department to an eligible recipient, whether by grant or contract, involving Federal, State or other funds for which the Department has administrative responsibility and authority.

"Client" means a person who receives services under a Department-funded program by a provider.

"Demonstration" means a project wherein money is awarded for a period of time to eligible recipients in order to evaluate the feasibility and efficacy of alternative methods of attaining the goals and purposes of the Act.

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"Department" means the Department of Human Services.

"Fee-for-service" means payments are made on the basis of a rate, unit cost or allowable cost incurred and is based on a statement or bill as required by the Department. Payments made as a fee-for-service are not subject to the Illinois Grant Funds Recovery Act [30 ILCS 705].

"Grant-in-aid" means a program receives all or part of the funding in advance of the actual delivery of services. This includes prorated prospective payments and payments made by the Department on an estimated basis or any other basis when the Department does not know the actual amount earned by the Provider. This does not include advance payments made under the authority of Section 9.05 of the State Finance Act [30 ILCS 105/9.05]. All funds paid as a grant are subject to the Illinois Grant Funds Recovery Act [30 ILCS 705].

~~"Imminent Harm" is an immediate and present threat of harm upon admission that requires 24 hour monitoring to prevent serious medical or physical consequences as a result of substance use. There is a high likelihood of harmful consequences within the next 24 hours if substance abuse continues. A possible risk of future harm is not necessarily imminent and would not require Level III.5 admission.~~

~~"Marked Impairment In Functioning" is when an individual demonstrates a repeated pattern of behavior as a result of substance use in which they are unable to provide for their self care needs, unable to maintain health, or maintain basic functional status.~~

~~"Medically Necessary" describes those services which: are reasonably necessary for the diagnosis or treatment of a chemical dependency disorder in order to improve or maintain an individuals level of functioning resulting from such a disorder; are in accordance with professionally accepted standards of care; are the most appropriate level of service and furnished in the most appropriate and least restrictive setting in which services can be safely provided; and could not be omitted without adversely affecting the individuals mental and/or physical health or the quality of care rendered.~~

~~"Medical Necessity" is a finding made by the Department or its designated agent that is required for the reimbursement of adult or adolescent residential treatment (ASAM Level III.5) services. The determination of medical necessity occurs~~

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~~during the Department's Utilization Management process pursuant to 2030.108 and 2030.109.~~

~~"Medical Practice Act of 1987" [225 ILCS 60] means the State law requiring a license to practice medicine in all branches of medicine in Illinois.~~

"Provider" means any public or private nonprofit agency, organization, or institution, or unit of state or local government, or a for-profit agency where an award to such would be appropriate and consistent with the purposes of the Act (as set forth in Sections 1-102 and 4-101 of the Act) and the funding source, or other legal entity to which an award is made by the Department, and which is accountable to the Department for the use of the funds provided. The term "provider" does not include individuals who ultimately receive benefits under or are volunteers participating in any funded program. Generally the term refers to programs which receive awards, and which actually provide intervention, prevention, and/or treatment services.

"Purchased care" means a specific type of fee-for-service as set forth in the Individual Service Payment System Manual compiled by the Department's Office of Purchased-Care.

"Recipient" is a general term for any person or organization which receives an award or subaward under this Part. It includes but is not limited to the terms provider and subprovider.

"Secretary" means the Secretary of the Department of Human Services or his or her designee.

"Subaward" means financial assistance in the form of money, property or services, in lieu of money, made under an agreement by a provider to an eligible subprovider or a recipient to an eligible subrecipient. The term includes financial assistance when provided by award, subgrant, contract or subcontract, but does not include procurements or commodities and supplies or incidental support services such as janitorial, catering, laundry, or building maintenance services.

"Subprovider" means any public or private nonprofit award recipient, organization, institution or unit of state or local government, or a for-profit agency where an award to such would be appropriate and consistent with the purposes of the Act and the funding source, or other legal entity to which a subaward is made

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and which is accountable to the provider and the Department for the use of the funds. The subprovider is the entire legal entity even if only a particular component of the entity is designated in the subaward document. This definition does not include persons or entities which provide incidental support services or supplies, materials or equipment to funded programs. Generally the term refers to programs which are recipients of awards and which actually provide intervention, prevention, and/or treatment services.

"Terms of an award or subaward" means all requirements of the award or subaward whether in statute, regulations, or the award document.

~~"Utilization Management" is the evaluation of the medical necessity, appropriateness, and efficiency of the use of alcohol and other drug treatment services, procedures, and facilities under the provisions of the DHS-DASA reimbursement benefits authority.~~

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days)

## SUBPART B: APPLICATION AND FUNDING

**Section 2030.105 Services Eligible for Grant-in-Aid Funding****EMERGENCY**

Grant-in-aid awards shall be made to support alcohol and other drug abuse prevention, intervention, treatment and appropriate related services, such as sanctuaries, as well as demonstration projects or research, as deemed appropriate under the powers and duties of the Department (as set forth in Section 4-101 of the Act). The following service functions are eligible for such grants:

- a) Adult residential rehabilitation ~~services~~, as defined and licensed under [the Licensure of the Alcoholism and Substance Abuse Treatment, and Intervention and Research Programs Licenses](#) (Licensure Rules), 77 Ill. Adm. Code ~~2058 2060~~ ~~determined to be a medical necessity by the Utilization Management process pursuant to Sections 2030.108 and 2030.109;~~
- b) Adolescent residential rehabilitation ~~services~~, as defined ~~in the and licensed under~~

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~~Alcoholism and Substance Abuse Treatment and Intervention Licenses in the (Licensure Rules), 77 Ill. Adm. Code 2060, determined to be a medical necessity by the Utilization Management process pursuant to 2030.108 and 2030.109;~~

- c) Halfway house, as defined in the Licensure Rules;
- d) Adult social setting detoxification, as defined in the Licensure Rules;
- e) Adult medical detoxification, as defined in the Licensure Rules;
- f) Adolescent medical detoxification, as defined in the Licensure Rules;
- g) Adult outpatient, as defined in the Licensure Rules;
- h) Adolescent outpatient, as defined in the Licensure Rules;
- i) Adult intensive outpatient, as defined in the Licensure Rules;
- j) Adolescent intensive outpatient, as defined in the Licensure Rules;
- k) Adult medical detoxification outpatient, as defined in the Licensure Rules;
- l) Intervention services to provide screening, assessing, referring and tracking of drug abuse clients, as defined in the Licensure Rules;
- m) Sanctuaries;
- n) Recovery homes;
- o) Early intervention activities;
- p) Prevention activities as set forth in Section 2030.1320 herein; and
- q) Other appropriate alcohol and drug abuse services.

The direct services and any ancillary or support services of the program which are allowable expenses under this Part may be supported by the grant as set forth herein.

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(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days)

**Section 2030.107 Services Eligible for Purchased-Care or Fee-for-Service Funding**  
**EMERGENCY**

The service functions eligible for grant-in-aid support may also be eligible for purchased-care or fee-for-service. The Department pursuant to this Section shall determine the appropriate method of award based on its objectives and how to best serve the needs of the State (as set forth in Department planning documents and Section 4-101 of the Act). ~~ASAM Level III.5 services that are eligible for purchased-care or fee-for-service funding are subject to the requirements of the Department's Utilization Management process pursuant to Section 2030.105(a) and (b).~~

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days)

~~**Section 2030.108 Medical Necessity for ASAM Level III.5 Treatment**~~  
~~**EMERGENCY**~~

- a) ~~The Prior Approval Review process outlined in 2030.109(a) shall be utilized to obtain authorization for reimbursement of adult or adolescent ASAM Level III.5 services unless a patient meets the criteria listed in Subpart 2 for the Concurrent Approval Review process. When authorization prior to admission is required, the Department or its designated agent shall determine if services are medically necessary by evaluating the following criteria:~~
- 1) ~~Specific substance abuse or dependence diagnosis using the ICD-9 diagnostic codes; and~~
  - 2) ~~Current, active substance use and deterioration in functioning; and any of the following:~~
    - A) ~~Outpatient treatment failure;~~
    - B) ~~Refusal of outpatient care; or~~

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- ~~c) Unavailable outpatient care.~~
- b) ~~The Concurrent Approval Review process outlined in 2030.109(b) shall be utilized when the criteria listed below are present. The Department or its designated agent shall determine if services are medically necessary, after admission, by evaluating the following criteria:~~
- ~~1) Specific substance abuse or dependence diagnosis using the ICD-9 diagnostic code; and~~
  - ~~2) Current, active substance use and deterioration in functioning; and~~
  - ~~3) Imminent harm; or~~
  - ~~4) Marked impairment in functioning.~~
- e) ~~The following are clinical criteria that may prevent admission to Level III.5 treatment, among other factors:~~
- ~~1) Acute intoxication of a severity that requires 24 hour medical monitoring;~~
  - ~~2) Acute withdrawal of a severity that requires 24 hour medical monitoring;~~
  - ~~3) Medical conditions that are unstable that require a level of medical care beyond the capacity of the ASAM III.5 setting;~~
  - ~~4) Psychiatric conditions that are unstable that require a level of medical care beyond the capacity of the ASAM III.5 setting; or~~
  - ~~5) Opioid dependence that would be more appropriately treated in an Opioid Treatment Program (OTP).~~

(Source: Added by emergency rulemaking at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days)

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**EMERGENCY**

- a) ~~Prior Approval Review:~~
- 1) ~~Organizations requesting prior authorization for reimbursement of adult or adolescent ASAM Level III.5 services must submit to the Department or its designated agent documentation demonstrating that the services are medically necessary and receive approval before admission.~~
  - 2) ~~Prior approval reviews will be conducted by qualified professional staff.~~
  - 3) ~~Organizations will be notified of the reimbursement decision within 2 full state business days of the request.~~
  - 4) ~~If the request is approved, the notice will include the number of treatment days for which reimbursement is authorized~~
  - 5) ~~If prior approval is not obtained, organizations will not be reimbursed.~~
- b) ~~Concurrent Approval Review:~~
- 1) ~~Organizations requesting concurrent authorization for reimbursement of adult or adolescent ASAM Level III.5 services must submit to the Department or its designated agent documentation demonstrating that the services are medically necessary within 1 full state business day after admission.~~
  - 2) ~~Concurrent approval reviews will be conducted by qualified professional staff.~~
  - 3) ~~Organizations will be notified of the reimbursement decision within 2 full state business days of the request.~~
  - 4) ~~If the request is approved, the notice will include the number of treatment days for which reimbursement is authorized.~~
  - 5) ~~If the request is denied, organizations will not be reimbursed.~~
- e) ~~Continued Treatment Review:~~

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- 1) ~~Organizations must submit documentation to the Department or its designated agent demonstrating that continued services are medically necessary 2 full state business days before the last day of authorized reimbursement for each patient previously approved for adult or adolescent ASAM Level III.5 services.~~
  - 2) ~~Continued treatment reviews will be conducted by qualified professional staff.~~
  - 3) ~~Organizations will be notified of the reimbursement decision within 2 full state business days of the request.~~
  - 4) ~~If the request for continued treatment is approved, the notice will include the number of additional days reimbursement is authorized.~~
  - 5) ~~If the request for continued treatment is denied, organizations will only be authorized reimbursement for any previously approved treatment.~~
- d) ~~First Level Clinical Review~~
- 1) ~~If reimbursement for an admission or continued treatment is denied, organizations may request a first level clinical review by the Department or its designated agent within 1 full state business day after receipt of the denial.~~
  - 2) ~~First level clinical reviews will be conducted by a clinical supervisor.~~
  - 3) ~~Organizations will be notified of the first level clinical review decision within 2 full state business days of the request.~~
  - 4) ~~If the request is approved, the notice will include the number of treatment days for which reimbursement is authorized.~~
  - 5) ~~If the request is denied, organizations will only be authorized reimbursement for any previously approved treatment.~~
- e) ~~Second Level Clinical Review:~~

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- 1) ~~If a first level clinical review for an admission or continued treatment is denied, organizations may request a second level clinical review from the Department or its designated agent within 1 full state business day after receipt of the denial.~~
  - 2) ~~A second level clinical review must, at a minimum, include a review and discussion of all relevant clinical information by the Departments or its designated agents physician and organizations designated physician.~~
  - 3) ~~Organizations will be notified of the second level clinical review decision within 2 full state business days of the request.~~
  - 4) ~~If the request is approved, the notice will include the number of treatment days for which reimbursement is authorized.~~
  - 5) ~~If the request is denied, organizations will only be authorized reimbursement for any previously approved treatment.~~
- f) ~~Final Administrative Decision:~~
- 1) ~~If the second level clinical review is denied, the organization may appeal in writing to the Secretary within 2 full state business days after receipt of the denial.~~
  - 2) ~~No additional evidence or documentation may be provided for the appeal.~~
  - 3) ~~The Secretary or his or her designee shall issue a Final Administrative Decision regarding the appeal.~~
  - 4) ~~If any Final Administrative Decision determines Level III.5 services are not medically necessary, organizations will only be authorized reimbursement for any previously approved treatment.~~
- g) ~~Judicial Review:~~  
~~The Final Administrative Decision shall be subject to Judicial Review exclusively as provided in the Administrative Review Law [735 ILCS 5/Art.III].~~
- h) ~~Any qualified professional staff conducting Utilization Management for the Department or its designated agent pursuant to subsection (a), (b), (c) or (f) shall~~

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENTS

~~meet the requirements for professional staff as defined in 77 Ill. Adm. Code 2060.309(a) or (c)(1).~~

- i) ~~Any clinical supervisor conducting Utilization Management for the Department or its designated agent pursuant to Section (d) or (f) shall meet the requirements for professional staff as defined in 77 Ill. Adm. Code 2060.309(a) or (c)(1), and have a minimum of 2 years experience in a licensed substance abuse treatment facility.~~
- j) ~~Any physician conducting Utilization Management for the Department or its designated agent pursuant to subsection (e) or (f) shall be licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60].~~

(Source: Added by emergency rulemaking at 35 Ill. Reg. 1448, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7737, effective April 28, 2011, for the remainder of the 150 days)

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

- 1) Heading of the Part: Subacute Alcoholism and Substance Abuse Treatment Services
- 2) Code Citation: 77 Ill. Adm. Code 2090
- 3) Section Number: 2090.35                      Emergency Action:  
Repeal
- 4) Statutory Authority: Implementing and authorized by Section 5-10 of the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301/5-10]
- 5) Effective Date of Repeal of Emergency Amendment: April 28, 2011
- 6) If this emergency repeal of emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: This emergency repeal of emergency amendment will expire on June 5, 2011.
- 7) Date filed with the Index Department: April 28, 2011
- 8) A copy of the emergency repeal of emergency amendment, including any material incorporated by reference, is on file with the agency's principal office and is available for public inspection.
- 9) Reasons for Emergency: The emergency repeal of emergency amendment is in response to the Joint Committee on Administrative Rules Objection that indicated that DHS' new utilization management policy presented a potential threat to the public safety, interest and welfare of adolescent patients receiving treatment programs under Medicaid.
- 10) A Complete Description of the Subjects and Issues Involved: This emergency repeal of emergency amendment removes all language in Section 2090.35 that was added as a result of the emergency rule that was effective January 7, 2011. This is a companion rule to 77 Ill. Adm. Code 2030.
- 11) Are there any proposed amendments to this Part pending? Yes  

<u>Section Number:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
2090.35	Amendment	35 Ill. Reg. 1329; January 21, 2011
- 12) Statement of Statewide Policy Objectives: To clearly indicate to the public and providers that the utilization management program has ceased.

DEPARTMENT OF HUMAN SERVICES

NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

- 13) Information and questions regarding this emergency repeal of emergency amendment shall be directed to:

Tracie Drew, Chief  
Bureau of Administrative Rules and Procedures  
Department of Human Services  
100 South Grand Avenue East  
Harris Building, 3<sup>rd</sup> Floor  
Springfield, Illinois 62762

217/785-9772

The full text of the Emergency Repeal of Emergency Amendment begins on the next page:

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

TITLE 77: PUBLIC HEALTH  
CHAPTER X: DEPARTMENT OF HUMAN SERVICES  
SUBCHAPTER g: MEDICAID PROGRAM STANDARDSPART 2090  
SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT SERVICES

Section	
2090.10	Purpose
2090.20	Definitions
2090.30	Medicaid Certification/Enrollment/Recertification
2090.35	General Requirements
	<a href="#">EMERGENCY</a>
2090.40	Reimbursable Services
2090.50	Quality Improvement
2090.60	Client Records
2090.70	Rate Setting
2090.80	Rate Appeals
2090.90	Inspections
2090.100	Sanctions for Non-Compliance/Audits
2090.105	Inspections (Renumbered)
2090.110	Sanctions for Non-Compliance (Renumbered)

AUTHORITY: Implementing and authorized by Section 5-10 of the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301/5-10].

SOURCE: Adopted at 11 Ill. Reg. 2236, effective January 14, 1987; emergency amendments at 12 Ill. Reg. 11273, effective June 30, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 20061, effective November 26, 1988; emergency amendments at 15 Ill. Reg. 10222, effective June 25, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 16662, effective November 1, 1991; amended at 16 Ill. Reg. 11807, effective July 14, 1992; amended at 18 Ill. Reg. 14223, effective September 2, 1994; amended at 19 Ill. Reg. 9411, effective July 1, 1995; amended at 19 Ill. Reg. 10454, effective July 1, 1995; emergency amendment at 20 Ill. Reg. 12489, effective August 30, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 1600, effective January 27, 1997; recodified from the Department of Alcoholism and Substance Abuse to the Department of Human Services at 21 Ill. Reg. 9319; emergency amendment at 21 Ill. Reg. 14087, effective October 9, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 5895, effective March 13, 1998; emergency amendment at 22 Ill. Reg. 12189, effective June 24, 1998, for a maximum of 150 days; emergency expired November 21, 1998; amended at 22 Ill. Reg. 22403, effective

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

December 8, 1998; emergency amendment at 23 Ill. Reg. 8832, effective July 23, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13879, effective November 4, 1999; emergency amendment at 26 Ill. Reg. 4426, effective March 8, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 12631, effective August 1 2002; amended at 27 Ill. Reg. 14022, effective August 8, 2003; emergency amendment at 35 Ill. Reg. 1465, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7754, effective April 28, 2011, for the remainder of the 150 days.

**Section 2090.35 General Requirements****EMERGENCY**

- a) To be reimbursable, treatment services shall be provided in compliance with all provisions specified in 77 Ill. Adm. Code 2060. Specifically, physician and professional staff involvement in treatment services shall be in compliance with 77 Ill. Adm. Code 2060.417, 2060.419, 2060.421, 2060.423 and 2060.425. The provider shall only bill for services that are reimbursable.
- b) The provider shall submit Medicaid claims as soon after the service date as is reasonable unless there is good cause for later submission. In any event, all claims for services (both initial and previously rejected) must be submitted to the State on a timely enough basis to be paid within 12 months from the date of service. If such claims are not submitted within this time frame, the provider may request an exception from the Department and IDPA to allow these claims to be processed. Exceptions will only be granted if it is determined that the delay in submission was due to Department or IDPA processing errors.
- c) Information Collection
  - 1) The provider shall report, on a monthly basis, demographic and service system data using the Department's Automated Reporting and Tracking System (DARTS), in the manner and data format prescribed by the Department. The data collected shall be for the purpose of assessing individual client performance and for planning for future service development. Information to be reported by the provider, for each individual served by a program certified under Section 2090.90 of this Part, shall include but is not limited to the following:
    - A) Name, date of birth, gender, race and national origin, family size, income level, marital status, residential address, employment,

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

education and referral source.

- B) Special population designation, such as Medicaid eligible clients, women with dependent children, intravenous drug users (IVDUs), DCFS clients, DHS clients, and criminal justice clients.
  - C) Drug/alcohol problem areas treated, characterized by drugs of use, frequency of use, and medical diagnosis.
  - D) Closing date information, such as the reason for discharging the client from the program.
- 2) The Department shall supply providers with DARTS software.
  - 3) Disclosure of information contained within DARTS is governed by the specific provisions of federal regulations under Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR 2 (1997)) and the Health Insurance Portability and Accountability Act, 42 USC 1320d et seq., and the regulations promulgated thereunder at 45 CFR 160 and 164, to the extent those regulations apply to the provider and the information that is contained within DARTS.
- d) The reimbursement limits herein shall not be applied in situations where to do so would deny an eligible individual under age 21 from receiving "early and periodic screening, diagnostic and treatment services" (ESPSDT) as defined in 42 USC 1396d(r). With the exception of adolescent residential rehabilitation as specified in Section 2090.40(c)(1) of this Part, services as set forth in this Part shall be reimbursable to an eligible individual under age 21 for as long as the services are clinically necessary pursuant to review which is consistent with subsection (a) of this Section. (The reimbursement limit for adolescent residential rehabilitation services as set forth in Section 2090.40(c)(2) of this Part is not considered to be a denial of required, early and periodic screening, diagnostic and treatment services.)
  - e) The reimbursement limits herein shall not be applied where to do so would deny services to a pregnant woman that have been determined to be clinically necessary pursuant to review which is consistent with subsection (a). This exemption from the limits exists during the pregnancy and through the end of the month in which the 60-day period following termination of the pregnancy ends (post partum

## DEPARTMENT OF HUMAN SERVICES

## NOTICE OF EMERGENCY REPEAL OF EMERGENCY AMENDMENT

period), or until the services are no longer clinically necessary, whichever comes first. This exemption shall not apply to a woman who enters treatment services after delivery.

- f) The provider shall not be reimbursed for services delivered in more than one Medicaid covered subacute alcoholism or other drug abuse level of care per client per day except for ancillary psychiatric diagnostic services.
- g) Group treatment in Level I and II care shall be reimbursed only for up to 12 clients per group that are supported by any type of Department contract funding.
- h) ~~Any adult or adolescent residential treatment (ASAM Level III.5) service must be determined to be a medical necessity by the Utilization Management process pursuant to 77 Ill. Adm. Code 2030.108 and 77 Ill. Adm. Code 2030.109.~~

(Source: Amended by emergency rulemaking at 35 Ill. Reg. 1465, effective January 7, 2011, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 35 Ill. Reg. 7754, effective April 28, 2011, for the remainder of the 150 days)

## ILLINOIS ENVIRONMENTAL AGENCY

## NOTICE OF PUBLIC INFORMATION

## Petition for Exemption from Section 22.23b of the Environmental Protection Act

Sub Zero Freezer Company, Inc. 4717 Hammersley Road, Madison, WI, 53711, has submitted a petition to the Illinois Environmental Protection Agency ("Illinois EPA") for an exemption from Section 22.23b of the Illinois Environmental Protection Act ("Act") [415 ILCS 5/22.23b]. Section 22.23b of the Act states that "no person shall sell, offer to sell, distribute, or offer to distribute a mercury switch or a mercury relay individually or as a product component." 415 ILCS 5/22.23b. The manufacturer of a mercury switch or mercury relay may petition the Illinois EPA for an exemption from Section 22.23b for one or more specific uses of the switch or relay. Requirements for the petition and procedures for the Illinois EPA's review of the petition can be found in Section 22.23b(c) of the Act [415 ILCS 5/22.23b(c)] and in Illinois EPA rules at 35 Ill. Adm. Code 182.

Pursuant to 35 Ill. Adm. Code 182.302(a), the Illinois EPA is providing public notice of the following information:

1. The petitioner is identified above. An exemption is sought for mercury flame sensors in outdoor grills. The exemption request is for replacement parts only.
2. The flame sensors are used in safety valves to prevent possible accumulation of gas should the pilot go out with the hood closed.
3. A copy of the petition is available for review at the Illinois EPA's headquarters. Persons wanting to review the application may do so during normal business hours at:

Illinois EPA Headquarters  
1021 North Grand Avenue East  
Springfield, IL 62794-9276  
Phone 217-524-9642, TDD 217-782-9143

Please call ahead to assure that someone will be available to assist you.

4. Written public comments on the petition may be submitted to the Illinois EPA for a period of 45 days after the date of publication of this notice. Comments must be submitted to the following address:

ILLINOIS ENVIRONMENTAL AGENCY

NOTICE OF PUBLIC INFORMATION

Becky Jayne, MC #34  
Illinois EPA  
1021 North Grand Avenue East  
P. O. Box 19276  
Springfield, IL 62794-9276

Phone 217-524-9642, TDD 217-782-9143  
E-mail: [Becky.Jayne@illinois.gov](mailto:Becky.Jayne@illinois.gov)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF WITHDRAWAL OF PROPOSED RULES IN RESPONSE TO THE  
JOINT COMMITTEE ON ADMINISTRATIVE RULES OBJECTION AND  
FILING PROHIBITION

1) Heading of the Part: Cemetery Oversight Act

2) Code Citation: 68 Ill. Adm. Code 1249

3) Section Numbers:                      Action:

1249.10	Withdrawal
1249.20	Withdrawal
1249.30	Withdrawal
1249.40	Withdrawal
1249.50	Withdrawal
1249.60	Withdrawal
1249.70	Withdrawal
1249.100	Withdrawal
1249.110	Withdrawal
1249.120	Withdrawal
1249.130	Withdrawal
1249.140	Withdrawal
1249.150	Withdrawal
1249.160	Withdrawal
1249.170	Withdrawal
1249.180	Withdrawal
1249.200	Withdrawal
1249.210	Withdrawal
1249.220	Withdrawal
1249.230	Withdrawal
1249.300	Withdrawal
1249.310	Withdrawal
1249.320	Withdrawal
1249.330	Withdrawal
1249.400	Withdrawal
1249.410	Withdrawal
1249.420	Withdrawal
1249.430	Withdrawal
1249.440	Withdrawal
1249.450	Withdrawal
1249.460	Withdrawal
1249.470	Withdrawal

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF WITHDRAWAL OF PROPOSED RULES IN RESPONSE TO THE  
JOINT COMMITTEE ON ADMINISTRATIVE RULES OBJECTION AND  
FILING PROHIBITION

- 4) Date Notice of Proposed Rules Published in the Illinois Register: 34 Ill. Reg. 5047; April 9, 2010
- 5) Date JCAR Statement of Objection and Filing Prohibition Published in the Illinois Register: November 5, 2010; 34 Ill. Reg. 16991
- 6) Summary of Action Taken by the Agency: At its meeting on April 12, 2011, the Joint Committee on Administrative Rules voted to withdraw the prohibition against the filing of this Department of Financial and Professional Regulation rulemaking contingent upon and effective with DFPR's filing a Notice of Withdrawal of the rulemaking with the Secretary of State. In response, the Department is withdrawing the rulemaking effective April 27, 2011. Pending legislation, when passed, will require the Department to propose a new rule to implement the changed statute.

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of April 26, 2011 through May 2, 2011 and have been scheduled for review by the Committee at its May 10, 2011 or June 14, 2011 meetings. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start Of First Notice</u>	<u>JCAR Meeting</u>
6/9/11	<u>Department of Central Management Services,</u> Pay Plan (80 Ill. Adm. Code 310)	3/11/11 35 Ill. Reg. 3874	5/10/11
6/10/11	<u>Department of Central Management Services,</u> Extensions of Jurisdiction (80 Ill. Adm. Code 305)	1/21/11 35 Ill. Reg. 1289	5/10/11
6/10/11	<u>Illinois Racing Board,</u> Medication (11 Ill. Adm. Code 603)	2/14/11 35 Ill. Reg. 2564	5/10/11
6/10/11	<u>Department of Public Health,</u> Hearing Instrument Consumer Protection Code (77 Ill. Adm. Code 682)	1/28/11 35 Ill. Reg. 1508	5/10/11
6/15/11	<u>Department of Public Health,</u> Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)	11/29/10 34 Ill. Reg. 18104	6/14/11
6/15/11	<u>Department of Public Health,</u> Sheltered Care Facilities Code (77 Ill. Adm. Code 330)	11/29/10 34 Ill. Reg. 18201	6/14/11
6/15/11	<u>Department of Public Health,</u> Illinois Veterans' Homes Code (77 Ill. Adm. Code 340)	11/29/10 34 Ill. Reg. 18286	6/14/11

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

## SECOND NOTICES RECEIVED

6/15/11	<u>Department of Public Health, The Manufacturing, Processing, Packing or Holding of Food (77 Ill. Adm. Code 730)</u>	1/3/11 35 Ill. Reg. 169	6/14/11
6/15/11	<u>Department of Public Health, Grade A Pasteurized Milk and Milk Products (77 Ill. Adm. Code 775)</u>	1/3/11 35 Ill. Reg. 175	6/14/11
6/15/11	<u>Department of Financial and Professional Regulation, Land Sales Registration Act of 1999 (68 Ill. Adm. Code 1260)</u>	3/11/11 35 Ill. Reg. 3882	6/14/11
6/15/11	<u>Department of Human Services, Temporary Assistance for Needy Families (89 Ill. Adm. Code 112)</u>	2/4/11 35 Ill. Reg. 1818	6/14/11
6/15/11	<u>Department of Human Services, Aid to the Aged, Blind or Disabled (89 Ill. Adm. Code 113)</u>	2/4/11 35 Ill. Reg. 1832	6/14/11
6/15/11	<u>Department of Human Services, General Assistance (89 Ill. Adm. Code 114)</u>	2/4/11 35 Ill. Reg. 1844	6/14/11
6/15/11	<u>Department of Human Services, Supplemental Nutrition Assistance Program (SNAP) (89 Ill. Adm. Code 121)</u>	2/4/11 35 Ill. Reg. 1856	6/14/11

## GUBERNATORIAL PROCLAMATION

**2011-156**  
**GUBERNATORIAL PROCLAMATION**

The series of severe storms producing high wind, tornadoes and torrential rain that have moved through the lower Midwest during the past two weeks continue to impact the southern half of the State of Illinois. The repeated heavy rainfall is resulting in flash flooding as the storms move through the State. Rivers and streams are above flood stage due to the extensive runoff from the saturated ground, causing long-term flooding in low lying areas. The continued flooding in areas already impacted by the severe storms is causing widespread damage to homes, businesses, roads, bridges and other public infrastructure. Other areas along the Ohio and Mississippi Rivers have a high potential for further flooding in the next few weeks.

In the interest of aiding the citizens of Illinois and local governments responsible for ensuring public health and safety, I hereby proclaim that a disaster exists within the State of Illinois pursuant to the provisions of Section 7 of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7.

This gubernatorial proclamation of disaster will aid the Illinois Emergency Management Agency in coordinating State resources to support the local governments impacted by the severe storms in their disaster response and recovery operations, including, but not limited to, emergency purchases necessary for response and other emergency powers as authorized by the Act. This includes the suspension of provisions of the Illinois Procurement Code that would in any way prevent, hinder or delay necessary action in coping with the disaster. Resources from all State agencies will be made available as reasonably necessary to assist those counties affected by the disaster in their effort to protect the public's safety and in preventing property damage to the extent possible.

Date: April 25, 2011  
Filed: April 25, 2011

**ILLINOIS ADMINISTRATIVE CODE**  
**Issue Index - With Effective Dates**

Rules acted upon in Volume 35, Issue 20 are listed in the Issues Index by Title number, Part number, Volume and Issue. Inquiries about the Issue Index may be directed to the Administrative Code Division at (217) 782-7017/18.

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