

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUPPORTIVE LIVING FACILITIES PROVIDER HANDBOOK

CHAPTER C-200

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Supportive Living Facilities

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SUPPORTIVE LIVING PROGRAM

C-200 PROGRAM DESCRIPTION

= The Public Aid Code (305 ILCS 5/5-5.01a) calls for the Department to establish and provide oversight for a program of supportive living facilities (SLFs) that seek to promote independence, dignity, respect and well-being in the most cost-effective manner. SLFs shall serve persons with a disability aged 22 years or over or persons who are aged 65 and over that meet the requirements described in Section C-220 of this handbook. SLFs shall be designated a provider type 28 and category of service 87. Definitions of terms used under this program are found in Appendix C-27 of this handbook.

C-210 STRUCTURAL REQUIREMENTS

**C-211 Resident Apartments General Requirements - Freestanding Sites and
Rehabilitated Nursing Facilities**

Each SLF apartment in a freestanding site shall have at least 300 square feet of living space, including closet(s) and bathroom, for a person living alone. Individuals wishing to share an apartment shall have no less than 450 square feet of living space, including closet(s) and bathroom.

Any nursing facility rehabilitating a portion of the facility to conform with SLF requirements shall convert a distinct part of existing facility space. Each SLF apartment shall have at least 160 square feet of living space, including closet(s) and bathroom, for a person living alone. Individuals wishing to share an apartment shall not have less than 320 square feet of living space, including closet(s) and bathroom.

Each apartment shall be equipped at a minimum with:

- a door that locks from the inside;
 - a full bathroom as defined in this section;
 - emergency call system pursuant to 89 Ill. Adm. Code 146.210;
 - heating and cooling controls;
- =
- access to cable television, satellite dish, or master antenna that receives at least ten channels; and
 - a sink; microwave oven or stove; and refrigerator with a separate freezer compartment.

Each freestanding SLF shall consist of one building housing at least 10 but no more than 150 apartments. Each rehabilitated nursing facility shall consist of a distinct part of an existing facility housing at least 10 apartments but no more than 150 apartments.

C-212 Building Construction

Each SLF shall be in compliance with the provisions contained in 89 Ill. Adm. Code, 146.210. The areas of building construction identified in the Code are as follows:

- General Requirements
- Heating and Air Conditioning
- Illumination
- Apartment Bathrooms
- Closet Space
- Doors
- Windows
- Common Areas
- Public Restrooms
- Public Telephone
- Social and Recreational Areas
- =Kitchen
- =Dining Area
- Laundry Room
- Housekeeping and Maintenance Areas
- Smoking Areas
- Water Services
- Waste Removal

C-220**PARTICIPATION REQUIREMENTS**

Facilities or distinct parts of facilities which are selected as SLFs and are in good standing with provisions governing SLFs contained in 89 Ill. Adm. Code, Part 146 are exempt from the provisions of the Nursing Home Care Act (210 ILCS 45/1 et seq.) and the Illinois Health Facilities Planning Act (20 ILCS 3960/1 et seq.). Nursing facilities rehabilitating a portion of the facility shall be allowed to bank their nursing facility beds until the conclusion of the project or until the facility wishes to withdraw from the project and convert the SLF beds back to nursing facility beds.

In order to become certified by the Department and participate in the Medical Assistance Program, a SLF must:

- complete and submit an application pursuant to 89 Ill. Adm. Code 146.215 (c) (1).
- Submit to the Department information identified in 89 Ill. Adm. Code 146.215 (c) (2) and (3).
- =Pass an on-site review conducted by the Department or its designee which includes, but is not limited to, a review of items identified in 89 Ill. Adm. Code 146.215 (c)(4).
- Execute a Medicaid provider agreement.

C-221**Enrollment**

=The Department will initiate action to secure the enrollment of a facility upon notification that the facility has passed the on-site review required under 89 Ill. Adm. Code 146.215 (c)(4). An enrollment packet will be provided consisting of Forms: HFS 1432B, SLF Provider Agreement/Enrollment; HFS 2314, Payment to Corporate Owner/Assurances; HFS 2316, Limited Power of Attorney; and completion instructions.

PROCEDURE: Form HFS 1432B, SLF Provider Agreement/ Enrollment, must be completed by each facility. Other forms included in the enrollment packet are optional. All completed forms are to be printed in black ink or typewritten.

After reading the conditions of participation, the facility manager's signature and the signature date must be entered in black ink on Form HFS 1432B.

Form HFS 1432B and all copies of any of the other forms in the packet which the facility elects to complete are to be returned within ten (10) days of receipt by the facility. Send the completed, signed form(s) to:

Illinois Department of Healthcare and Family Services
Bureau of Long Term Care
201 South Grand Avenue East
Springfield, Illinois 62763-0001

C-222 Limited Power of Attorney

The Billing Certification located on the last page of Form HFS 194-M-1, Remittance Advice, retained in the facility's files must show the name of the facility's manager.

It must be the actual, original signature of the manager or the manager's name signed by an agent authorized by the manager and followed by the agent's initials.

The enrollment packet includes three copies of Form HFS 2316, Limited Power of Attorney. Completion and submittal of this form is not required when the facility manager will actually sign each form submitted. If, however, the manager desires to designate another facility employee to sign the manager's name on Form HFS 194-M-1, Form HFS 2316 must be completed and submitted to the Department's Central Office. If the manager desires to name more than one agent (a maximum of three may be designated) a separate Form HFS 2316 must be completed and submitted for each agent.

PROCEDURE: Legibly complete all entry fields on Form HFS 2316 in black ink. The name and the address of the facility and printed name entries may be printed or typewritten. The form is to be completed for each agent designated and sent to:

Illinois Department of Healthcare and Family Services
Bureau of Long Term Care
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Even though a designated agent signs a form, the manager retains full responsibility for the information contained therein.

When an agent leaves employment and/or the facility desires to designate another employee to assume this responsibility, promptly notify the Department in writing at the above address of the name of the person to be deleted and enclose the newly completed Form HFS 2316.

When a facility manager changes, the new manager has the option of personally signing the forms or designating another employee of the facility, not to exceed three agents, to sign his or her name. If the new manager designates an agent(s), a newly completed Form HFS 2316 must be submitted to the Department for each employee named even though the same employee(s) may have been designated by the previous manager.

Telephone the Bureau of Long Term Care (BLTC) at (217) 782-0545 when additional copies of Form HFS 2316 are needed.

C-223 Payment To Corporate or Partnership Owner's Address

At the discretion of the Department, a facility and its corporate or partnership owner may have the facility's payment (warrant) sent directly to the business address of the corporate or partnership owner. The warrant will be issued in the name of the facility but sent to the business address of the corporate or partnership owner rather than the facility.

The Department requires completion of Form HFS 2314, Payment to Corporate Owner/Assurances, prior to authorizing this payee procedure. Form HFS 2314 must be completed by the corporate or partnership owner. A Form HFS 2314 must be signed and dated by the chief executive officer of the corporate or partnership owner and the manager of each facility included in the special payee arrangement. In signing Form HFS 2314, both the corporate or partnership owner and the facility's manager acknowledge their special commitment to the Department for the following assurances:

1. The facility will maintain and make available to the Department, such records as are necessary to fully disclose the extent of the care or services rendered to residents.
2. The facility will maintain and make available to the Department, such information regarding any payments claimed by the facility for providing care or services to residents as the Department may request. If such records are maintained at the central office location of the corporate or partnership owner, the corporate or partnership owner will make them available at the facility location at the request of the Department. Copies of Form HFS 194-M-1, Remittance Advice, will be maintained at the facility.
3. The facility and the corporate or partnership owner will maintain and make available all the financial records that may be requested by the Department, specifically including the records that set forth the terms of the relationship between the facility and its owner.
4. The facility and the corporate or partnership owner will retain full responsibility for all payments made. This responsibility includes liability to repay any overpayments made by the Department.
5. In accepting Department payments, the facility warrants that it shall review all remittance advices that accompany payments and shall certify that all services specified therein are a true, accurate and complete record of services rendered by the facility. Furthermore, the facility agrees to review, affix an original signature, and retain in its files the Billing Certification which is the last page of the remittance advice.

The facility shall promptly notify the Department when it becomes aware of changes in services that may effect Department payment, provided that such notice shall in no event be made more than thirty days after the facility's receipt of any incorrect or incomplete remittance advice(s). The Department shall recover any overpayments that may occur as a result of the facility's failure to timely notify the Department of changes or corrections in services provided by set off, crediting against future billings or by requiring direct repayment to the Department.

6. None of the officers, directors, or shareholders (of 5% or more of the shares of stock) of the corporate or partnership owner have been barred from participation in the Medical Assistance Program.
7. The facility and the corporate or partnership owner will notify the Department if ownership interest in the facility is transferred. Additionally, the facility and the corporate or partnership owner will notify the Department if any of the information on the Form HFS 2314 changes.

PROCEDURE: Form HFS 2314, Payment to Corporate Owner/Assurances, must be completed to allow retention of an original copy by the Department for each facility completing Form HFS 2314.

A Form HFS 2314, Payment to Corporate Owner/Assurances, must be completed for each facility requesting an alternative payee address. Submit HFS 2314 for each facility to:

Illinois Department of Healthcare and Family Services
Bureau of Long Term Care
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Upon approval of the alternate payee procedure, the Department will generate and distribute a Provider Information Sheet (see Appendix C-25) to the appropriate facilities reflecting the change in address. The Department reserves the right to withdraw approval of the alternate payee procedure at any time.

When the Department has previously approved the special payment arrangement to the business address of a corporate or partnership owner and a facility not previously included desires to be added to the special payee arrangement, the request must be initiated in writing by the facility.

Send the request to the address indicated in this topic. The Department will supply Form HFS 2314 for appropriate completion as described herein. The newly completed Form HFS 2314 is to include the name, address and provider number of the facility to be added and list similar information for each facility previously approved for which the arrangement is to continue. Each form is to be sent to the Department. When the change has been approved, the Department will generate and distribute a Provider Information Sheet applicable to that facility.

=To delete a facility from the special payment arrangement, a **written** request to the Department must be initiated by the facility rather than the corporate or partnership owner. No forms need to be completed. The Department will delete the facility from the Form HFS 2314 listing and generate a new Provider Information Sheet to reflect the change.

C-224 Renewal of Certification

Unless the SLF is notified by the Department 30 days prior to termination of the contract, certification is automatically renewed.

The Department shall refuse to renew a certification, pursuant to 89 Ill. Adm. Code 146.280, if the SLF is not in compliance with all applicable laws and statutes, ordinances, codes or Department rules and requirements for the SLF.

C-225 Change of Ownership

SLF certification is not transferable or applicable to any location, provider, management agent or ownership other than that indicated on the Medicaid provider agreement and contract. The new ownership shall comply with the applicable certification requirements found in 89 Ill. Adm. Code 146.215.

The Department shall be notified 60 days prior to a change of ownership or management. Change of ownership means a change of five percent or more. The Department has the right to terminate its contract with the SLF if the change of ownership involves a barred Medicaid provider. The new ownership shall comply with the applicable certification requirements found in 89 Ill. Adm. Code 140.215. The SLF shall comply with enrollment conditions identified in 89 Ill. Adm. Code 140.11.

The Department shall conduct an on-site certification review not less than at the time of the next annual certification review or within three months of the effective date of the change of ownership. SLF certification shall be deemed to extend to the new owner until the Department separately certifies the SLF under the new owner.

C-226 Voluntary Surrender of Certification

A SLF shall inform the Department in writing if it intends to voluntarily surrender its certification from the Medical Assistance Program. The notification shall be received by the Department at least 90 days prior to the date of surrender. The Department will make SLF payments only through the day prior to the effective date of voluntary surrender.

C-227 Termination or Suspension of SLF Provider Agreement

=The Department may terminate, suspend, or not renew the provider agreement subject to the provisions of 89 Ill. Adm. Code 140.16 and 146.280.

C-230 RESIDENT PARTICIPATION REQUIREMENTS

- = The SLF may admit or retain Medicaid residents whose needs can be met through the services described in Section C-250. These persons would typically have a score of 29-47 on the Determination of Need (DON) and need assistance in one or more activities of daily living. These persons must meet all of the following criteria:
- Be age 22 years and over with a disability (as determined by the Social Security Administration) or elderly aged 65 years and over.
 - =Be screened by the Department and found to be in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individuals. A new screen is not needed for a resident who is transferring between SLFs or comes from a nursing facility with no break in service. It is the admitting SLF's responsibility to ensure that a screening document is received from the transferring SLF or nursing facility. Private pay individuals may choose to be admitted into an SLF when the screening assessment does not justify nursing facility level of care.
 - =Be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. (Developmental disability is defined as a disability which is attributable to mental retardation or a related condition.) The developmental disability or mental illness must be determined by a qualified Department of Human Services screener.
 - =
 - =Have name checked against the Illinois Sex Offender Registration website at www.isp.state.il.us and/or the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us Refer to 89 Ill. Adm. Code 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF.

C-231 Screening

All private pay individuals seeking admission to a SLF shall be screened by the Department. Private pay individuals who choose to be admitted into a SLF when the screening assessment does not justify nursing facility level of care need not be denied access to the SLF. Private pay residents seeking to convert to Medicaid while residing in a SLF shall be screened prior to the point of conversion by the Department and shall be found to be in need of nursing facility level of care before Medicaid payment may be authorized.

Documentation of screening results shall be recorded on a completed Form HFS 2536, Interagency Certification of Screening Results for each person. A screening assessment is valid for 90 calendar days from the date of the assessment. There are no situations which would allow backdating of a screening assessment.

C-232 Appeal for Screening Results

When the results of the screening completed at the time of admission do not show the need for nursing facility services, the potential resident is entitled to an appeal of the screening results. If the screening was completed by a Department designee, such as the Department on Aging, notification of the right to appeal will be given to the potential resident by the designee's representative. The hearing process will be handled through the designated agency.

If the screening completed at the time of admission or at the time of conversion to Medicaid was completed by the Department, notification of the right to appeal will be given the potential resident or resident by the Department. The hearing process will be completely handled through the Department.

=NOTE: A finding of mental illness does not necessarily prevent a resident from entering a supportive living facility. Revisions to 89 Ill. Adm. Code 146.220(a)(3) on October 18, 2004, allow admission of a person with mental illness if the condition is not serious and persistent. In the event an individual is determined to not be appropriate due to mental illness, an appeal may be requested to determine if the identified mental illness meets the above criteria.

Using Form HFS 3733, Case Action Notice to Resident, the potential resident or resident is notified by the Department of the results of the failed screening and of the right to appeal (the SLF is notified of the screening results through Form HFS 2536, Interagency Certification of Screening Results).

The potential resident or resident must file Form HFS 3734, Notice of Appeal, within 60 days of the date of notice of the failed screen.

The Department will conduct an informal review and notify the potential resident or resident of the review results within 21 days of receipt of the appeal request. The notification will be done using Form HFS 3735, Appeal Notice Informal Review Findings.

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Appeal for Screening Results (continued)

- If the informal review overturns the failed screen, an amended Form HFS 2536, Interagency Certification of Screening Results, will be sent to the SLF for inclusion in the admission package sent to the Department of Human Services (DHS) local office (Nursing Home Services in Cook County).
- If the informal review upholds the failed screen, the Department will automatically notify its Bureau of Administrative Hearings (BAH) to schedule a formal hearing.

NOTE: The resident or potential resident may withdraw his or her appeal request at any time during the appeal process by using Form HFS 3736, Request For Withdrawal of Appeal.

BAH will schedule a formal hearing and notify the potential resident or resident.

BAH will conduct a hearing, render its decision and notify the potential resident or resident within 90 days of the receipt of the appeal request.

- If the formal hearing overturns the failed screen, an amended Form HFS 2536, Interagency Certification of Screening Results, will be sent to the SLF for inclusion in the admission package sent to the DHS local office (Nursing Home Services in Cook County).
- If the formal hearing upholds the failed screen, payment for supportive living services under the Medical Assistance Program will not be authorized by DHS.

C-233

=Reserved

C-234

Discharge

If a resident does not meet the terms for occupancy as stated in the resident contract, discharge proceedings shall not commence until there has been discussion with the resident and his or her designated representative concerning the reason for involuntary discharge.

Discharge (Continued)

The SLF shall provide a resident with 30 days written notice of proposed discharge using Form HFS 3731, Notice of Involuntary Discharge, unless such a delay might jeopardize the health, safety, and well-being of the resident or others. A SLF may provide the 30 day written notice on the first day of a unpaid temporary absence or at any point during a unpaid temporary absence (see Section C-245, Temporary Absence).

A resident may be involuntarily discharged only if one or more of the following occurs:

- He or she poses an immediate threat to self or others.
- He or she needs mental health services to prevent harm to self or others.
- He or she has breached the conditions of the resident contract.
- The SLF has had its certification terminated, suspended, not renewed, or has voluntarily surrendered its certification.
- The SLF cannot meet the resident's needs with available support services.
- The resident has received proper notice of failure to pay by the SLF. This does not apply to Medicaid residents when the failure to pay relates to the Medicaid payment. The resident shall have the right to redeem up to the date that the discharge is to be made and then shall have the right to remain in the SLF.
- =The resident exceeds the SLF's policy for what constitutes a temporary absence from the SLF. A temporary absence shall not be considered a basis for an involuntary discharge of a Medicaid resident until the Department has stopped payment.

The above referenced 30 day notice does not apply in any of the following instances:

- When an emergency discharge is mandated by the resident's health care or mental health needs and is in accord with the written orders and medical justification of the attending physician.
- When the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record.

A request to the Department for hearing of the involuntary notice of discharge shall stay a discharge pending a hearing or appeal of the decision, unless a condition which would have allowed discharge in less than 30 days as described above develops in the interim.

C-235 Appeal of Involuntary Discharge

Attached to Form HFS 3731, Notice of Involuntary Discharge will be Form HFS 3732, Involuntary Discharge Notice of Appeal and Request for Hearing, which may be used by the resident to request an appeal. An appeal may be filed by mail or by phone with BAH. The address and toll-free number are located on the appeal request form.

NOTE: The resident may withdraw his or her appeal request at any time during the appeal process by using Form HFS 3736, Request For Withdrawal of Appeal.

Upon receipt of Form HFS 3732, Involuntary Discharge Notice of Appeal and Request For Hearing, BAH will schedule a hearing and notify the resident and the SLF.

BAH will conduct a hearing, render its decision and notify the resident and the SLF within 90 days of the receipt of the appeal request.

- If the hearing overturns the involuntary discharge, the resident may remain in the SLF.
- If the hearing upholds the involuntary discharge, the resident is discharged no less than 10 days from receipt of the hearing decision.

C-240 REIMBURSEMENT AND PAYMENT FOR MEDICAID RESIDENTS

The service portion of the rate shall be paid by the Department on a monthly basis. The service portion of the rate shall be established by contract with the Department.

C-241 Room and Board Charges - Single Occupancy

=Each Medicaid resident of a SLF shall be allotted a minimum of \$90 per month as a deduction from his or her income as a protected amount for personal use. The SLF may charge each Medicaid resident no more than the current SSI rate for a single individual less \$90 for room and board charges. Any income remaining after deduction of the protected \$90 and room and board charges shall be applied first towards medical expenses not covered under the Department's Medical Assistance Program. Any income remaining after that shall be applied to the charges for SLF services paid by the Department. Unless authorized by the Department, additional payment for room and board may not be charged or accepted. The SLF may collect any food stamp benefits from a SLF resident in accordance with the terms of the resident contract.

The room and board charge for Medicaid residents shall only be increased when the SSI amount is increased. Any room and board charge increase shall not exceed the amount of the SSI increase.

C-242 Room and Board Charges - Double Occupancy

=In the event a Medicaid eligible resident chooses to share an apartment, the Medicaid resident of a SLF shall be allotted a minimum of \$90 per month as a deduction from his or her income as a protected amount for personal use. The SLF may charge each Medicaid resident no more than the resident's share of the current SSI rate for a couple less \$90 for room and board charges. The room and board rate for two Medicaid eligible individuals sharing a room cannot exceed the SSI rate for a married couple even if the two individuals sharing a room are unrelated. Any income of an individual remaining after deduction of the protected \$90 and room and board charges shall be applied first towards that individual's medical expenses not covered under the Department's Medical Assistance Program. Any income of an individual remaining after that shall be applied to that individual's charges for SLF services paid by the Department. Unless authorized by the Department, additional payment for room and board may not be charged or accepted. The SLF may collect any food stamp benefits from a SLF resident in accordance with the terms of the resident contract.

The room and board charge for Medicaid residents shall only be increased when the SSI amount is increased. Any room and board charge increase shall not exceed the amount of the SSI increase.

If one, or both, of the individuals sharing an apartment is not Medicaid eligible, the SLF is free to negotiate its own rate with the non-Medicaid individual(s).

C-243 Authorization for Payment

=The first step in the payment process is authorization for payment. Payment can be made only for those residents for whom a completed Form HFS 2299, Long Term Care Authorization, has been data entered into the Department's computer system. A copy of the completed form is provided to the facility. Authorization for payment cannot be completed until resident eligibility is established; and the facility has provided the caseworker with copies of forms: HFS 1156, Long Term Care Facility Notification, HFS 2536, Interagency Certification of Screening Results, HFS 26, Report on Resident of Private Long Term Care Facility, and OBRA-1.

=Form HFS 2449A, LTC Transaction Report by Facility will be sent to each SLF indicating the transactions that were performed by the caseworker during the reporting week. The transactions recorded on this weekly report include changes in level of care and patient credit amounts and death/discharge dates. Facility staff should review this report to ensure its accuracy.

All facilities are to keep the caseworker advised of changes on a timely basis utilizing Form HFS 1156, LTC Facility Notification, to enable the local office to data enter all change actions as a single transaction. Facilities are to submit a completed Form HFS 1156, to the caseworker reporting a resident's death within five business days. If the facility has not contracted with a REV vendor, the facility should also fax a copy of the HFS 1156 to the Exceptions Processing Unit at (217) 557-4210 within five days of the resident's death.

C-244 Date of Payment

=If the screening requirements are met prior to admission, payment for care will be approved on the latter of:

- the date the screening occurred; or
- the beginning date of eligibility.

=A screening is required for a person converting from private pay to Medicaid after admission. However, the date of the screening does not affect the date of payment authorization except that payment cannot be authorized until a screening has been done. Payment for care will be approved on the beginning date of eligibility.

C-245 Temporary Absence

Effective August 1, 2004, the Department will reimburse facilities during a Medicaid resident's temporary absence from the SLF for up to 30 days per state fiscal year. The resident shall continue to be responsible for room and board charges during any temporary absence.

As a temporary absence occurs, the SLF manager or designated employee (designated as having limited power of attorney) is to submit Form HFS 2234, Bed Reserve/Temporary Absence Form, for each resident in the SLF who is absent from the SLF for one or more days of the service period.

The definition and reserve bed codes to be used on Form HFS 2234 are:

- 10 - Payable Bed Reserve - Hospital Stay.
- 11 - Nonpayable Bed Reserve - Hospital Stay.
- 20 - Payable Absence - Other temporary absence.
- 21 - Nonpayable Absence - Other temporary absence

C-245 Temporary Absence (continued)

An SLF resident entering another long term care facility, such as a nursing facility, must be discharged from the system even if the nursing facility stay is temporary (i.e., rehabilitation following a hospitalization). This is accomplished by completing a Form HFS 1156, LTC Notification, and submitting it to the local Department of Human Services office. No temporary absence reimbursement will be made while a SLF resident is temporarily in a nursing facility.

C-246 Paperless Billing System

Each month, the Department will generate Form HFS 3402, LTC Pre-Payment Report which will provide client specific information taken from the Recipient Data Base and will be the same information used to authorize payment. At the same time, a claim record will be generated. The claim records will be used to authorize payment to each facility.

The provider can expect to receive the payment amount reflected on the report provided that : 1) no outstanding credits due the Department are taken; and 2) no claims reject. Form HFS 194-M-1, Remittance Advice will be enclosed with the warrant at the time payment is sent to the facility.

=If the provider feels there is a discrepancy with payment, Form HFS 3725, Payment Review Request Form, may be completed and submitted to the Bureau of Long Term Care. Instructions for the completion of this form and the address to which it is to be sent are on page two.

C-247 Certification of Payment

Each facility will be required to review, affix an original signature and retain in its files, a billing certification statement which will be located on the last page of the remittance advice that certifies that all services specified are a true, accurate and complete record of services rendered by the facility. The certification statement must be retained a minimum of three years in the facility.

C-248 Adjustments

Refer to General Handbook, Chapter 100, Topic 132 for Adjustment policy and procedures. The following is a description of each system.

C-248 Adjustments (continued)

=The Mass-to-Detail Adjustment System is the first type of adjustment system. This system processes adjustments based upon the SLF rate changes and temporary absence changes, in addition to all the types of changes made by the automated adjustment processes. This adjustment system is normally scheduled to process at the beginning of the month. Mass-to-Detail makes adjustments to temporary absence and changes made to the Recipient Data Base. It is normally processed for actual payment on the third weekend of the month.

= The Automated Adjustment System is the second type of adjustment system that is initiated monthly and runs after the Mass-to-Detail Adjustment. This system processes adjustments based upon changes made to the individual resident's record on the data base. The Automated Adjustment System picks up all transaction changes made to the Recipient Data Base since the last processing date. Adjustments result from changes initiated by the SLF electronically or through their Department of Human Services local office caseworker. This adjustment system also recovers overpayments made to SLFs due to retroactive discharges.

Under either of these systems, if the total outcome is a debit, the facility will receive a warrant with the remittance advice. If the outcome is a credit, the amount will be posted to the facility file and deducted from future payments made by the Department.

C-249 Retroactive Rate Changes

When, for any reason, the Department approves an increase or decrease in a facility's reimbursement rates on a retroactive basis, the Department will automatically initiate adjustments for the services paid at the incorrect rate by using either of the above referenced systems.

COVERED SERVICES

A SLF must combine housing, personal and health-related services in response to the individual needs of residents who need help in activities of daily living. Supportive services shall be available 24-hours per day to meet scheduled and unscheduled needs in a way that promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and autonomy in a residential setting.

The payment rate received by the SLF from the Department for services provided in accordance with this Section shall constitute the full and complete charge for services rendered. Additional payment, other than patient credits authorized by the Department, may not be accepted.

Each SLF shall be in compliance with the provisions contained in 89 Ill. Adm. Code, Part 146.230. The services identified in the Code are as follows:

- Nursing Services
- Medication Oversight and Assistance in Self-Administration
- Personal Care
- Meals
- Laundry
- Housekeeping
- Maintenance
- Social and Recreational Programming
- Ancillary Services
- Health Promotion and Exercise Programming
- Emergency Call System

C-260 RECORD AND REPORTING REQUIREMENTS

C-261 Resident Records

Each SLF shall develop and maintain confidential written resident records which shall include, but are not limited to:

- Assessment in accordance with 89 Ill. Adm. Code 146.245;
- Resident contract in accordance with 89 Ill. Adm. Code 146.240;
- =Service plan in accordance with 89 Ill. Admin. Code 146.245;
- =Progress notes which shall be used to document any significant involvement with the resident and results of any changes in the service plan; and
- =Resident satisfaction survey in accordance with 89 Ill. Adm. Code 146.215 (d)(3)(H); and
- =Written documentation of the inquiry to the sex offender data bases, including the result of the inquiry in accordance with 89Ill. Adm. Code 146.220.

C-262 Personnel Records

Each SLF shall develop and maintain confidential written personnel records which shall include, but are not limited to:

- Job description;
- Educational preparation and work experience;
- Current licensure or certification, if applicable;
- Documentation of annual performance evaluation;
- Documentation that employee has received personnel policies and procedures;
- =Documentation of on-going staff training;
- =Documentation of a tuberculosis test administered in accordance with 89 Ill. Adm. Code 146.235; and
- =Results from the health care worker background check conducted in accordance with 89 Ill. Adm. Code 146.235.

C-263 Quality Assurance Plan

In accordance with 89 Ill. Adm. Code 146.270, each SLF shall be responsible for establishing an effective, internal quality assurance plan which encompasses oversight and monitoring, peer review, utilization review, resident satisfaction and ongoing quality improvement, implementing any corrective action plans that address improved quality services.

C-264 Reports Submittal

The SLF shall be responsible for generating and submitting to the Department the following reports in accordance with 89 Ill. Adm. Code 146.265 (c).

- Personnel Report (see Appendix C-21) which shall be due initially no later than January 30th and July 30th of each calendar year and semi-annually thereafter.
- Resident Identification Report which shall be due monthly no later than 10 days after the end of each calendar month. Each resident who resided at least one day in the facility during the month is to be listed. This information is to be reported electronically on the Microsoft Excel spreadsheet provided electronically to all SLFs September 2004. SLFs that have been certified since that date have been provided the spreadsheet upon certification.
- Health Care Related Subcontractors and Manager Report which shall be due initially prior to enrollment in the Medical Assistance Program and as changes occur thereafter.
- Cost Reports which shall be submitted at any time upon request by the Department or when a significant change occurs in the SLF's financial status and annually not later than 90 days after the end of the SLF's fiscal year. One 30 day extension shall be granted when a written request is submitted prior to the original due date. Failure to file the cost report within these time frames shall result in the Department withholding reimbursement.
- Medication Error Report (see Appendix 30) that shall be completed as soon as an error is discovered and placed in the resident's record. Medication errors resulting in hospitalization of the resident shall also be reported to the Department within 24 hours of discovery.

C-265 Records Retention

Retention of all records shall be in accordance with provisions of 89 Ill. Adm. Code 140.28, the Federal Privacy Act (5 USC Section 552a), the Freedom of Information Act (5 ILCS 140/1 et seq.), the Comptroller Act (30 ILCS 505/6.i.) and the State Public Records Act (5 ILCS 160/1 et seq.). The SLF shall provide the Department or its designee with access to financial and other records which pertain to covered services. The SLF shall keep separate fiscal records in accordance with acceptable accounting procedures.

C-270 MONITORING

Monitoring and any oversight of the SLF shall be conducted by the Department or its designee. Designated Department staff shall coordinate the program, provide technical assistance and monitor compliance no less than annually with the items identified in 89 Ill. Adm. Code 146.215.

The Department shall investigate all complaints within seven days after receipt from a resident, a resident's designated representative, or others expressing concern related to the health and safety of the residents. The Department reserves the right to conduct a full certification review or to make referrals to other appropriate entities for additional action if the results of a complaint investigation indicate the need to do so.

A SLF shall not restrict or hamper access by Department-designated staff to the building, residents or designated records required to conduct routine or periodic reviews or investigations. A resident may limit access to his or her private dwelling space to inspectors, except for suspected violations that may pose a threat to the resident or others' health, safety or well-being. A resident may also elect to limit access to himself or herself and his or her records, except such as required as a condition of payment for housing and services by a third party.

Section III
APPENDIX C

C-1	HFS 26, Report on Resident of Private LTC Facility
C-1a	Instructions for Completion of Form HFS 26
C-2	HFS 194-M-1, Remittance Advice
C-2a	Explanation of Information on Form HFS 194-M-1
C-2b	Error Code Explanation
C-3	HFS 1156, LTC Facility Notification
C-3a	Instructions for Completion of Form HFS 1156
C-4	HFS 1432B, SLF Provider Agreement/Enrollment
C-5	HFS 2234, Long Term Care Bed Reserve/Temporary Absence Form
C-5a	Instructions for Completion and Submittal of Form HFS 2234
C-6	HFS 2299, LTC Authorization
C-6a	Explanation of Entries on Form HFS 2299, LTC Authorization
C-7	HFS 2314, Payment to Corporate Owner/Assurances
C-8	HFS 2316, Limited Power of Attorney
C-9	HFS 2378H, Request for Medical Assistance - Hospital/Nursing Home Application for Medical Assistance
C-10	Reserved
C-11	HFS 2449A, LTC Transaction Report by Facility
C-12	HFS 2536, Interagency Certification of Screening Results
C-13	HFS 3402, LTC Pre-Payment Report
C-13a	Instructions for the Review of the LTC Pre-Payment Report
C-14	HFS 3731, Notice of Involuntary Discharge
C-15	HFS 3732, Involuntary Discharge Notice of Appeal and Request For Hearing
C-16	HFS 3733, Case Action Notice to Resident
C-17	HFS 3734, Notice of Appeal
C-18	HFS 3735, Appeal Notice Informal Review Findings
C-19	HFS 3736, Request For Withdrawal of Appeal
C-20	= HFS 3869, SLF Medication Error Report
C-20a	= Instructions for the completion of HFS 3869, SLF Medication Error Report
C-21	SLF - Semi-Annual Personnel Report
C-22	SLF - Resident Identification Monthly Report

Section III
APPENDIX C
(Continued)

C-23	HFS SLF Rate Setting Areas Map
C-24	HFS SLF Rate Setting Areas by County
C-25	Provider Information Sheet
C-26	OBRA 1
C-27	Definitions
C-28	HFS 1156A, LTC EDI Update Information
C-29	HFS 3725, Payment Review Request Form

**EXPLANATION OF INFORMATION ON FORM HFS 194-M-1, REMITTANCE
ADVICE**

The following is an explanation of entries which may appear on the Remittance Advice.

1. **PROVIDER NUMBER** - This is the 12-digit number assigned by the Department of Healthcare and Family Services to the specific facility. It appears on the Provider Information Sheet as the Provider Key Number.
2. **TYPE** - This Department assigned code identifies the type of provider for whom the Remittance Advice is written.

28 - Supportive Living Facility (SLF)

3. **DATE** - This is the date the Remittance Advice is written.
4. **PAGE** - Each page is sequentially numbered.

The Remittance Advice reports the status of all adjudicated billing services and adjustment transaction processed. The information included in the body of the completed form is dependent upon the specific type of action being reported. The type of action reported will be printed in the center of the page preceding the report. The two types of action will appear on the Remittance Advice are:

- ADJUDICATED INVOICES
- ADJUSTMENTS

Adjudicated Invoices - Services listed in the first group include:

- services that are being paid in the full amount of total charges
- services that are being paid in an amount less than total charges
- services on which no payment is being made

For each service reported, the following entries will appear:

5. **DOCUMENT CONTROL NUMBER** - This is a unique number assigned by the Department.

6. **PROVIDER REFERENCE** - A number (up to 10 characters) appears here if one was entered.
7. **SECTION ALL** - This entry indicated that all line entries on the Pre-Payment Report had a type action taken.
8. **RECIPIENT NAME** - This entry identifies the name of the resident to whom the billed services were provided.
9. **RECIPIENT NUMBER** - This entry is the resident's unique 9-digit number that appears on the Medical Eligibility Card.
10. **SECTION** - This entry indicates the specific line on the Pre-Payment Report on which action is being reported.
11. **CATEGORY OF SERVICE** - This entry specifies the two-digit code number for the category of service for supportive living facilities were made on the line indicated.
12. **DATES OF SERVICE** - This entry specifies the beginning and ending dates for the category of service.
13. **DAYS** - This entry indicates the number of days of service for which payment is being determined.
14. **AMOUNT BILLED** - This entry specifies the total charge amount shown on the Pre-Payment Report. If the Remittance Advice reports more than one section, the charge shown will be the amount billed for the specific period of service.
15. **AMOUNT ALLOWED** - This entry specifies the amount paid on the Pre-Payment Report.
16. **STATUS** - This entry explains the action taken on the Pre-Payment Report:
 - PD - The total charge amount on the Pre-Payment Report was paid.
 - RD - The total charge amount on the Pre-Payment Report was reduced by the patient income credit amount with payment made at the net amount due.

RJ - Rejected, no payment made. Whenever this code is entered, an error code will be entered in the final column. See Appendix C-2b for an explanation of the various error codes which may appear on the Remittance Advice.

17. **TYPE OF STAY** - This two-digit code identifies one of the following types of stay for which adjudication is reported:

11 - Nonpayable Reserve Bed - Hospital stay
21 - Nonpayable Reserve Bed - Other

18. **ERROR CODE AND ERROR MESSAGE** - This entry is a three character code, one alphabetical (identifying the type of error as "R" for resident eligibility) and two numerical (identifying the particular error within that type), will appear to indicate the specific error which caused the rejection of payment. A brief error message on the line below the error code will specify the reason for the rejection.

19. **PATIENT CREDIT** - This entry reports the amount of the "Recipient Available Income" entered by the caseworker on Form HFS 2299, Long Term Care Authorization, and the "Total Credits" amount shown on the Pre-Payment Report for the same period of service.

Adjustments - The final group will report any adjustments made. Adjustments which cannot be processed as submitted and are not able to be corrected by Bureau of Long Term Care staff (by means of written correspondence or a telephone contact with the provider) will be returned to the facility. These rejected adjustments will not appear on the Remittance Advice.

For adjustments reported, the following entries will appear:

20. **DOCUMENT CONTROL NUMBER** - This is the unique number assigned by the Department to the adjustment when it is received. It appears on the green copy of the adjustment form when returned to the facility by the Department.
21. **RECIPIENT NAME** - This entry identifies the specific resident when a single service has been adjusted.
22. **RECIPIENT NUMBER** - This entry shows the specific resident's 9-digit recipient number when a single service has been adjusted.

23. **CATEGORY OF SERVICE** - This entry shows the specific category of service (see item 11 of this Appendix) from the specific service adjusted.
24. **DATE OF SERVICE** - This entry reports the ending date of the service period of the service adjusted.
25. **ADJUSTMENT** - This entry will appear in the "Item or Service" column. This entry will be ADJ followed by one of the Process Type codes which appear in box 23 of the green copy of the adjustment form sent to the facility. (See Appendix C-2a for an explanation of the Process Type codes.)
26. **AMOUNT ALLOWED** - This entry will show the amount being recovered (Credit) or the increase in the amount paid (Debit) as a result of the adjustment processed. When a check or warrant is returned by the facility, this entry will show the amount of the check or warrant.

For credit adjustments, the "amount allowed" entry will show the actual amount being recovered on the particular voucher (Remittance Advice). The amount may or may not equal the full credit amount shown on the adjustment sent to the facility. The amount could be less than the total amount to be recovered, e.g., in the case of adjustment Process Type 06C for an audit recoupment. The amount will represent the percentage of each payment to the provider that is being recovered and applied to the total amount to be recovered.

27. **STATUS** - One of the following code entries will appear for each adjustment:

DB - Debit which represents an increase in the amount paid.

CR - Credit which represents a decrease in the amount paid.

RT - Checks or warrants returned by the provider.

PS - A processed credit adjustment posted to the computer system. This amount of the credit will be taken from a subsequent warrant(s). The subsequent application of this credit will appear with the same Document Control Number and a status of CR (credit).

28. **PROVIDER SUMMARY** - This summary on the final page of the Remittance Advice will include all reported services and adjustments. The Amount Payable equals the Remittance Total amount which appears at the bottom of the final page and is equal to the warrant amount. Reading from top to bottom, the summary lines will appear as follows:

Total Billed
 Amount Rejected
 Amount Suspended

Total TPL
 Total Credits
 Total Debits
 Amount Payable
 Returned Checks

Adjustment amounts will not be included in the "Total Billed" amount. Credit and debit amounts will not be included in the "Amount Payable" amount but will be used in calculating the Remittance Total.

29. **VOUCHER NUMBER** - This entry is the unique number assigned to the specific Remittance Advice. It is to be used and appropriately identified as such in any correspondence and inquiries to the Department by the provider concerning information reported on the Remittance Advice.
30. **PROVIDER MAILING ADDRESS** - The address shown in this space will be the pay-to address specified on the provider's current Provider Information Sheet. The sixteen-digit number, above the payee name, may be disregarded by the facility as it is a control number by the Comptroller. This entry will be completed on each page of the same Remittance Advice.
31. **REMITTANCE TOTAL** - When the Remittance Advice consists of multiple pages, this element will be completed only on the final page. The amount entered will be the amount of the warrant (check) which accompanies the Remittance Advice. The amount of the Remittance Total will be equal to the Amount Payable plus Total Debits minus Total Credits.

ERROR CODE EXPLANATION

“D” Series - Miscellaneous Errors

The “D” series of rejects includes miscellaneous errors not otherwise listed.

Error Code	Message	Explanation	Procedure
DO1	DUPLICATE PAYMENT, VOUCHER	<p>A service period was generated which was a duplicate of one previously generated for this resident. The voucher number included in the message appears on the Remittance Advice (HFS 194-M-1) on which the previously paid service was reported.</p> <p>This rejection code will also appear on Form HFS 194-M-1 when a hospital has been paid for the same date of service as that submitted by the supportive living facility at the full per diem rate on the Pre-Payment Report.</p>	<p>1. NONE. Duplicate charges are not to be submitted. If after comparison with provider records the provider believes the charge is not a duplication, contact the Bureau of Long Term Care at:</p> <p>Ill. Department of Healthcare and Family Services Bureau of Long Term Care P.O. Box 19108 Springfield, Illinois 62708</p> <p>Include an explanation and attach any pertinent documentation which facility's reason for feeling the charge was not a duplication.</p>
D33 =	Inpt./Group Care Claim of Same Date	UB 92 and supportive living facility services processed for the same period. Resident was an inpatient in a hospital setting during the dates of service on the rejected service.	System will automatically enter a non-payable bed reserve to cover the inpatient hospital claim and rebill on next pre-payment report. If all or part of the bed reserve is payable submit a HFS 2234 to the Bureau of Long Term Care with the word “correct” written on the top of the form.

ERROR CODE EXPLANATION

“P” Series - Provider Errors

The “P” series of errors identifies **problems associated with provider eligibility**. In order to receive payment under the Medical Assistance Program, a provider must be approved for participation and be enrolled to provide the specific category of service for which charges are made.

Error Code	Message	Explanation	Procedure
P03	PROVIDER NOT ENROLLED FOR CAT SERV DATE SERV	After the Pre-Payment Report was mailed to the provider, the facility's data base information was changed on the computer either terminating participation or changing the effective date and/or the applicable category of service.	The provider is to review the Provider Information Sheet for correctness of the category of service and the beginning and ending enrollment dates. If data base needs correction, provide pertinent information to: Ill. Department of Healthcare and Family Services Bureau of Long Term Care P.O. Box 19108 Springfield, Illinois 62708 or telephone: (217) 782-0545
P05	PROV # NOT ON FILE	Provider number was changed on computer data base after Pre-Payment Report was mailed to provider. This error may occur when there is a change of ownership.	Provider should contact Bureau of Long Term Care as indicated above.
P07	PROV EXCEPTION IND	This provider exception indicator means that the provider is under exception for legal reasons, e.g., lien against payments by IRS.	If not previously informed, for explanation of reason for exception, contact Bureau of Long Term Care as indicated above.

ERROR CODE EXPLANATION

"R" Series - Recipient Errors

The "R" series of errors indicate that payment cannot be allowed on behalf of the resident for specific services provided during a specific period.

Error Code	Message	Explanation	Procedure
RO3	RECIP NOT ELIG ON DATE OF SERVICE	<p>A Pre-Payment Report was generated for a date(s) of service which does not fall within the range of the resident's medical eligibility period.</p> <p>The entire service may have been rejected or only a portion of the service period.</p> <p>If the resident was eligible during a portion of the service period shown on the Pre-Payment Report, payment will be shown for those dates of service when the resident was eligible.</p> <p>If the resident was eligible during a portion of the service period shown on the Pre-Payment Report, payment will be shown for those dates of service when the resident is eligible.</p>	<p>1. If the local Human Services office confirms that the resident was not eligible on the date(s) of service rejected for payment, the resident is liable for payment of the service.</p> <p>2. If the local Human Services office confirms that information on the computer Recipient Eligibility file was incorrect, local office must correct the file before payment can be made. Contact the Bureau of Long Term Care if assistance is needed in resolving the problem.</p> <p>Provide pertinent information to:</p> <p>Ill. Department of Healthcare and Family Services Bureau of Long Term Care P.O. Box 19108 or telephone: (217) 782-0545</p>

**=INSTRUCTIONS FOR COMPLETION AND SUBMITTAL OF FORM HFS 2234,
LONG TERM CARE BED RESERVE/TEMPORARY ABSENCE FORM**

The Department will reimburse a supportive living facility at 100 percent of the Medicaid per diem for up to 30 days per state fiscal year.

When a resident is absent from the supportive living facility during a service period, the facility is responsible for completion and submittal of Form HFS 2234, Long Term Care Bed Reserve/Temporary Absence Form.

The facility Manager, or a designated agent with limited power of attorney, is to complete Form HFS 2234. Entries are to be typewritten or printed in black or dark blue ink. Leave the Document Control Number box blank.

Entries are to be made as follows:

FACILITY INFORMATION - COMPLETED BY FACILITY

- Enter - in the appropriate boxes - the 12 digit Facility I.D. Number, Facility Name, and Facility Address, exactly as they appear on the Provider Information Sheet.
- An entry in the Facility Reference Number box is not required, it is optional for the facility. Up to 10 numerical and/or alphabetical characters may be entered.

RESIDENT INFORMATION - COMPLETED BY FACILITY

Enter the resident's name (first name, last name) and nine digit Recipient I.D. Number exactly as they appear on the recipient's current Medical Eligibility Card. Do not use the Case Identification Number.

TEMPORARY ABSENCE INFORMATION - COMPLETED BY FACILITY

An entry is to be made in each of the three boxes on the same line (bed type, begin date, end date). Enter the bed type code and related dates of service in chronological date order. Use one line for each bed reserve period that consists of one day or two or more consecutive days.

Bed Type - Enter the correct two digit code to describe the resident's stay status applicable to the dates entered on each line.

=10 - (Payable Temporary Absence) - Hospital stay days. Code 10 is to be used when cumulative number of days absent are less than 30 days per state fiscal year (SFY).

11 - (Nonpayable Temporary Absence) - Hospital stay days. Code 11 is to be used when the resident is temporarily absent from the facility due to a hospitalization and the cumulative number of days absent are in excess of 30 days per SFY.

20 - (Payable Temporary Absence) - Other temporary absence. Code 21 is to be used when the resident is temporarily absent from the facility due to a reason other than hospitalization and the cumulative number of days are less than 30 days per SFY.

21 - (Nonpayable Temporary Absence) - Other temporary absence. Code 21 is to be used when the resident is temporarily absent from the facility due to a reason other than hospitalization and the cumulative number of days absent are in excess of 30 days per SFY.

Begin Date - For Hospitalization - Enter the month, day and year of the first day of the temporary absence period using two digits for each entry; for example, the resident left on July 13, 2004, the begin date is reported as 071304 .

For Other - Enter the month, day and year of the day following the day the resident left the SLF to report the temporary absence period. Use two digits for each entry; for example, the resident left on July 13, 2004, the begin date is reported as 071404 .

End Date - Enter the month, day and year for the last day of the temporary absence using a six digit date as described above. The SLF will be paid for the day a resident returns to the SLF. Therefore, the end date is the date before the resident's return.

When the resident is discharged, use the actual date of discharge as the end date. The report of consecutive days related to a hospitalization should be shown on the same Form HFS 2234 when the final bed reserve day occurred beyond the last day of the billing period.

When reporting a absence other than hospitalization, the begin and end dates entered on Form HFS 2234 may not be prior to the first day or after the last day, respectively, of the billing period even though the resident remained out of the facility beyond the last day of the billing period.

TEMPORARY ABSENCE CERTIFICATION STATEMENT - COMPLETED BY FACILITY

The Administrator or designated agent is to sign and date the form to certify that all the information entered on the form is accurate and that the facility has met all requirements of the Department related to reserve bed days shown on the form. **If an employee as the Manager's designated agent signs the form, the Manager's name is to be signed followed by the employee's initials.**

SUBMITTAL INSTRUCTIONS

Submit the original to:

Illinois Department of Healthcare and Family Services
Post Office Box 19108
Springfield, Illinois 62794-9108

EXPLANATION OF ENTRIES ON FORM HFS 2299, LONG TERM CARE AUTHORIZATION

Form HFS 2299, Long Term Care Authorization, is completed by the caseworker to report the recipient's admission to the facility and initiate payment through the Central Office computer system. See Appendix C-8 for a copy. The first carbon copy is always given to the facility and is to be retained. The second carbon copy remains in the local office.

The following items on the form will be completed by the caseworker:

Section A - Transaction Information

Admit will be checked when one of the following situations occurs:

1. a Medicaid recipient is admitted to the facility
2. a private pay resident in the facility is determined eligible for Medicaid

All other items in Section A will be completed as appropriate.

Section B - Recipient General

The recipient name and recipient number must appear exactly as they appear on the recipient's medical eligibility card.

Diagnosis 1 will be entered on each form completed. An invoice will not be generated unless an entry appears here. Completion of Diagnosis 2 is optional.

The attending physician's name and number will be entered on each form completed. The number entered may be the physician's AMA Number, Social Security number or state license number.

If any of the above items are incomplete or incorrect, the facility administrator is to contact the caseworker.

Section C - Recipient Available Income

An entry will be made only if the recipient has income available to apply to the cost of long term care. The effective date and the amount of available income will be entered. This amount will appear as a credit on the turnaround billing invoice until a change is data entered. If changes are anticipated the caseworker will enter the appropriate dates and amounts. Those changes will appear on the turnaround billing invoice for the appropriate billing period. This section will be completed even in those instances in which a recipient has income greater than the amount of the Department payment rate if the recipient is receiving care during the period of Medicare Part A coverage. This will result in the issuance of a zero balance invoice.

Section D - Evaluation of Need for Care

Effective date is non-applicable.

End date is non-applicable.

Category of Service is the specific level of care for which payment is being authorized. This must agree with a type of service the facility is licensed to provide.

Evaluation date is the date of the caseworker's evaluation of need for care on which the authorization is based for Category of Service.

The Negotiated Rate is non-applicable.

Section E - Provider Information

The Facility I.D., name, and address will be entered exactly as they appear on the Provider Information Sheet. This information must be given to the caseworker by the facility administrator.

The Provider Reference Number will be entered only when the facility has provided such a number to the caseworker to identify the specific recipient in the facility records.

The caseworker's signature will appear on the form.

Appendix C-10

Reserved

All information entered on the form is to be reviewed by the facility administrator to ensure that it is all correct. If any of the information is incorrect, the caseworker should be contacted immediately so that a revision can be prepared.

INSTRUCTIONS FOR REVIEW OF THE LONG TERM CARE PRE-PAYMENT REPORT

Upon receipt of the Long Term Care Pre-Payment Report, the Facility should review the following items:

FACILITY INFORMATION

Review the provider name and provider number.

RECIPIENT INFORMATION

Recipient Name - last name, first name

Recipient Number - This is the nine digit recipient number.

Admit Date - This is the day the recipient was admitted to the facility.

Document Control Number (DCN) - This is a unique number assigned to each service period for each recipient.

Begin Date - This is the first day of the service period.

Days - This is the number of days being billed for the service period.

COS Bed - The category of service for that recipient (i.e., 87 - supportive living); or the bed type code (i.e., 11 - hospital stay).

Detail Charges - The gross charges for the recipients cost of care for the service period.

Patient Income - The amount determined by the local office as allowable income for the service period.

Net Charges - The difference between the patient income and the detail charges. This is the amount the Department of Healthcare and Family Services will pay for the service period.

Discharge Date - This statement appearing on this report is conditional upon the recipient having been discharged during the service period.

APPENDIX C-13a (2)

Discrepancies found on this report regarding patient credit changes, level of care and discharge should be reported to the Department's local office caseworker on Form HFS 1156, Notice of Change. Discrepancies regarding bed reserve should be reported on Form HFS 2234, Bed Reserve Form. If corrections to the discrepancies found on this report have already been submitted to the Department, they should be followed-up on after a reasonable amount of time to allow for processing.

INSTRUCTIONS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
Supportive Living Facility Medication Error Report

What errors need to be recorded?

ALL medication errors that occur for residents receiving medication management services from the SLF are required to be recorded. Medication management includes: medication set-up, reminders, assistance with self-administration (eg. cuing) and administration by licensed staff.

A medication error includes:

- wrong medication
- wrong dosage
- wrong time (*medication given within 1 hour of prescribed time is **NOT** considered an error*)
- wrong route
- missed medication

How are errors recorded?

The HFS Medication Error Report form must be completed each time an error is discovered.

ALL medications involved in the incident must be listed on the second page of the report form.

For instance, if a resident misses a dose of two different medications, a separate line should be completed for each medication involved.

What errors must be reported to HFS?

Any medication errors that result in adverse reactions requiring hospitalization must be reported to the HFS Regional Supervisor on the HFS Medication Error Report within **24 hours** of discovery.

All other medication errors shall be recorded on the HFS Medication Error report and kept on file for Department review.

7/7/07

**SUPPORTIVE LIVING FACILITY
Semi-Annual Personnel Report**

Section I. Identifying Information

Facility Name: _____ Phone #: _____ FAX #: _____
 Address: _____ Name of SLF Manager: _____
 _____ Person Completing Report: _____
 _____ Signature

Section II. Period of the Report

Time Period Covered by this Report: _____ to _____
 (date) (date)

Section III. Personnel Information

Name of Staff (List Alphabetically)		Title	Employment Date	Languages Spoken	Salary (hourly)	Total Hours Worked	Service(s) Performed (enter all that apply from the list below- use letter codes a-j)
Last Name	First Name						

Services

- a) nursing
- b) personal care
- c) medication oversight
- d) laundry
- e) housekeeping
- f) maintenance
- g) social and recreational programming
- h) ancillary
- i) 24 hour response/security staff
- j) health promotion and exercise programming

SLF - Resident Identification Monthly Report

SLF NAME									
MONTH OF REPORT									
Resident LastName	Resident FirstName	IDPA Resident ID	Admission Date	Date of Birth	Previous Residence Code	DON Score	Conversion Date	Discharge Date	Discharge Destination
Previous Residence Codes P1 - Private House P2 - Senior Independent Living Apt. P3 - Supportive Living Facility P4 - Assisted Living Facility - Not SLF P5 - Nursing Facility P6 - Other						Discharge Destination Codes D1 - Death D2 - Returned Home D3 - Transferred to Group Care Facility D4 - Admitted to Hospital D5 - Transferred to State-Operated Facility D6 - Left State D7 - Left County D8 - Unknown D9 - Other DS - Supportive Living Facility			

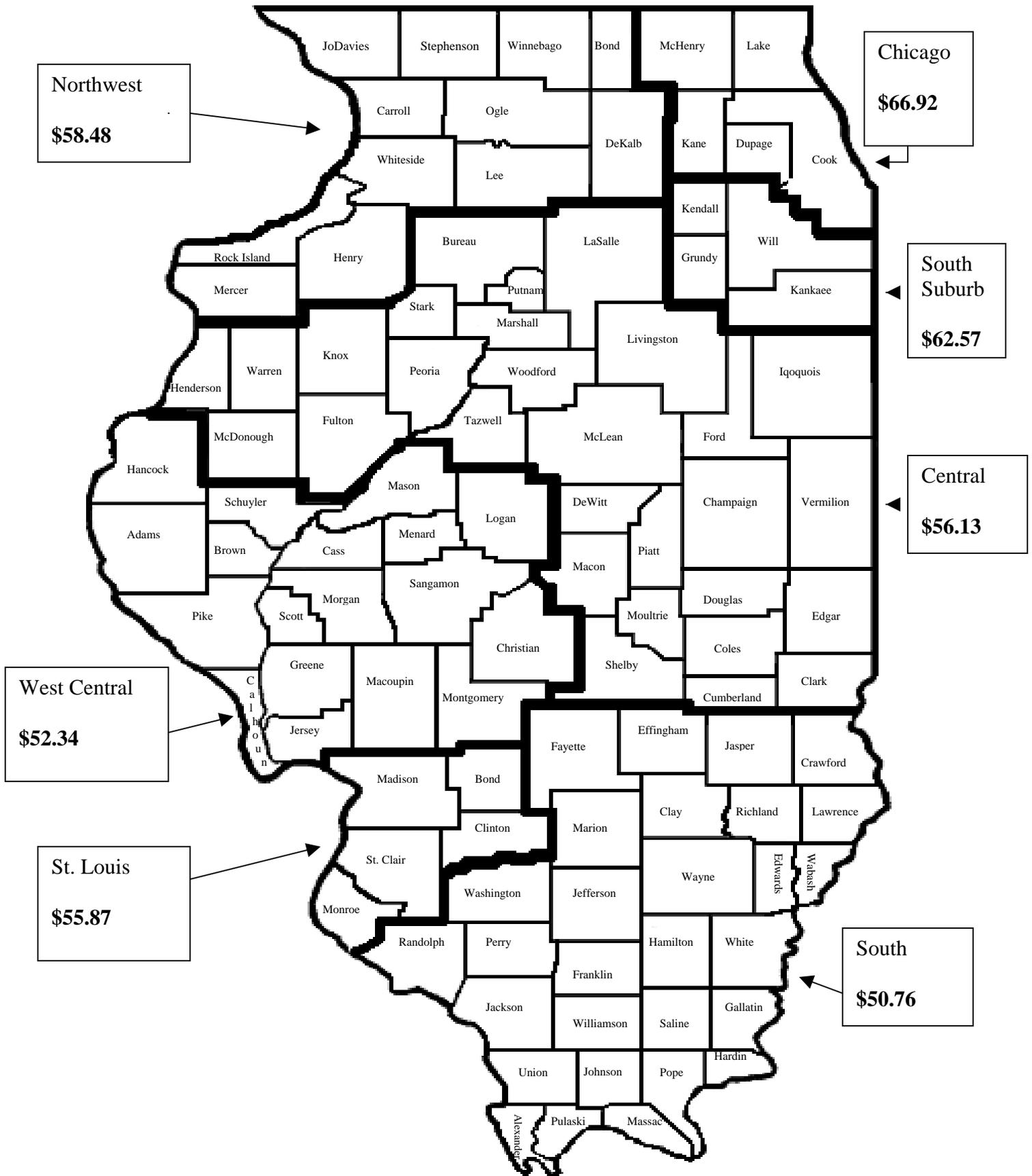
Supportive Living Facility Medicaid Rates

HFS LTC Rate Setting Area Grouping

FY07 Rates

Effective

04/01/2007



HFS SLF RATE SETTING AREAS BY COUNTY**Northwest**

Boone
 Carroll
 Dekalb
 Henry
 JoDaviess
 Lee
 Mercer
 Ogle
 Rock Island
 Stephenson
 Whiteside
 Winnebago

West Central

Adams
 Brown
 Calhoun
 Cass
 Christian
 Greene
 Hancock
 Jersey
 Logan
 Macoupin
 Mason
 Menard
 Montgomery
 Morgan
 Pike
 Sangamon
 Schuyler
 Scott

St Louis

Bond
 Clinton
 Madison
 Monroe
 St. Claire

Chicago

Cook
 DuPage
 Kane
 Lake
 McHenry

South Suburb

Kankakee
 Kendall
 Grundy
 Will

Central

Bureau
 Champaign
 Clark
 Coles
 Cumberland
 DeWitt
 Douglas
 Edgar
 Ford
 Fulton
 Henderson
 Iroquois
 Knox
 Lasalle
 Livingston
 Macon
 Marshall
 McDonough
 McLean
 Moultrie
 Peoria
 Piatt
 Putnam
 Shelby
 Stark
 Tazwell
 Vermilion
 Warren
 Woodford

South

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

MEDICAID SYSTEM (MMIS)
 PROVIDER SUBSYSTEM
 REPORT ID: A2741KD3
 SEQUENCE: PROVIDER TYPE
 PROVIDER NAME

STATE OF ILLINOIS
 HEALTHCARE AND FAMILY SERVICES

LONG TERM CARE/SUPPORTIVE LIVING PROVIDER INFORMATION SHEET

RUN DATE: 10/09/07
 RUN TIME: 08:11:36
 MAINT DATE: 10/09/07
 PAGE: 1

--PROVIDER KEY-- PROVIDER NAME AND ADDRESS PROVIDER TYPE: 028 - SUPP LIV FAC REGION BE
 364230987001 ACME HEALTHCARE CENTER ORGANIZATION TYPE: 02 - PARTNERSHIP LTC GROUP CODE 01
 604 W MAPLE ST CHICAGO IL 99999-9999 ENROLLMENT STATUS: A-ACTIV COST BEGIN 07/30/04 END ACTIVE
 LAST TRANSACTION: ADD AS OF 04/03/07
 COUNTY 036 FRANKLIN MEDICARE NUMBER:
 TELEPHONE NUMBER: (312) 123-1234 IDPH LICENSE NUM: EFF DATE:
 RE-ENROLLMENT INDICATOR: N DATE: 07/30/2004

INSTITUTION INFORMATION: FISCAL YEAR END: 12/31/04 HOLD ON PAYMENTS FOR NEW ADMISSIONS DATES BEGIN END

BED/APART USAGE	BED/APART CPTY	EFF DATE	FACILITY/CTL AFFIL	REVIEW CONTROL	BEGIN	END
S - SKILLED	0000	07/30/04	17-PARTNERSHIP			
I - INTERMEDIATE	0000	07/30/04		BLDG CODE 1000040		
C - SKILLED+INTERMED	0000	07/30/04				
N - SHELTER	0000	07/30/04				
B - INT. MENTAL HNDCP	0000	07/30/04				
L - SPEC LIV CENT	0000	07/30/04				
P - SKILLED PED	0000	07/30/04				
M - MED COV STAY	0000	07/30/04				
A - SUPPORTIVE LIVING	0100	07/30/04				

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEGIN DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEGIN DATE
087	LTC-SLF	07/30/04			

SUPPORT COST:	0.00	EFFECTIVE	CAPITAL COST:	0.00	EFFECTIVE
GER NURS COST:	0.00	EFFECTIVE	DD NURS COST:	0.00	EFFECTIVE
S/P NURS COST:	0.00	EFFECTIVE	SLC NURS COST:	0.00	EFFECTIVE
SLF COST:	50.76	EFFECTIVE 04/01/07			

EFF DATE	PAYEE	PAYEE NAME	PAYEE STREET	PAYEE CITY	STATE	ZIP	PAYEE ID NUMBER
07/30/04	1	ACME HEALTHCARE CENTER	604 W MAPLE ST	CHICAGO	IL	62812	364230987-62812-01
		DBA: ACME HEALTHCARE CENTER					TIN #: 01

FACILITY CLOSE DATE ACTIVE

NAME CHANGED TO: EFF DATE: NEW OWNERSHIP LICENSE NUMBER:

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:

***** PLEASE NOTE: *****

* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

*** ATTENTION: PROVIDERS SHOULD REFER TO THE DEPARTMENT'S WEB SITE AT <http://www.hfs.illinois.gov/>

OBRA-I INITIAL SCREEN
Identification of Individuals for Whom There is a Reasonable Basis to
Suspect a Developmental Disability or a Mental Illness

<p>PART I. IDENTIFYING INFORMATION</p> <p>Last Name: _____ First Name: _____ MI: _____ Social Security: _____ Birth Date: ____/____/____</p>
<p>Based upon all information and data available to me for this person there is a reasonable basis for suspecting DD or MI ___ Yes ___ No (If yes, proceed and complete Parts II and III below. If no, no further completion of this form is necessary, except signature and date at the bottom).</p>
<p>PART II. REASONABLE BASIS TO SUSPECT A DEVELOPMENTAL DISABILITY:</p> <p>1) The individual has been formally diagnosed with (<i>Circle applicable condition</i>): <i>Mental Retardation</i>, related condition such as <i>Cerebral Palsy, Epilepsy, Autism, or any other condition</i> (other than mental illness found to be closely related to mental retardation because this condition results in impairments of general intellectual functioning or adaptive behavior similar to that of individuals with mental retardation and requires services similar to those required for such individuals AND the condition was manifested prior to the age of 22. ___ Yes ___ No</p> <p>2) The individual experienced seizures prior to the age of 22. ___ Yes ___ No</p> <p>3) The individual has received special education and/or day program services. ___ Yes ___ No</p> <p>4) The individual remained at home with family and did not go to school or work. ___ Yes ___ No</p> <p>5) There are other indicators of mental retardation or developmental disability. ___ Yes ___ No Specify other indicator(s): _____</p>
<p>PART III. REASONABLE BASIS TO SUSPECT A MENTAL ILLNESS:</p> <p>1) The individual has been formally diagnosed with a mental illness verified by a DSMIV classification which substantially impairs the person's cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities, and alcohol/substance abuse. ___ Yes ___ No</p> <p>2) The individual has a history of psychiatric hospitalization. ___ Yes ___ No</p> <p>3) The individual has a history of outpatient mental health services. ___ Yes ___ No</p> <p>4) There are other indicators of mental illness. ___ Yes ___ No Specify other indicator(s): _____</p>

Signature _____ *Date* _____

Organization Name _____ Phone # _____

(Note: If any of the items in Part II or III are marked "yes", complete Part IV and refer to the appropriate DD PAS or MH PAS agent. Answering "yes" to any of the items does not automatically mean that the individual has a developmental disability or mental illness, only that the condition may exist. If all items are marked "no", the remaining parts of this form are not applicable. In that case, sign and date the form and proceed with the routine screen.

PART IV. (To be completed by the initial screener only if a "yes" is marked in any item in Part III or IV.) Based on the initial OBRA-I review, the individual has been referred to one of the following authorized pre-admission screening entities. Indicate the date of the referral. Indicate also the type and name of the organization to which the individual is being referred. (Note: If the determinations reflect both developmental disability and mental illness, refer the individual to the DD PAS agent.)

Date of Referral to Organization Indicated Below: ____/____/____

(Circle One): DD PAS MH PAS

Name of Organization to which the individual is being referred: _____

Part V. (To be completed only by a DD or MH PAS agent if he or she determines there is not a developmental disability or mental illness in the case of this referral.) Complete the information below.

Date of Referral to Organization Indicated Below: ____/____/____

1. Although an item was marked "yes" on the preceding page, the individual does not need a Level II assessment by this agency because:

2. The individual, therefore, is being referred as follows:

(Circle One): DD PAS MH PAS ORS Department on Aging

Name of Organization to which the individual is being referred: _____

Signature _____ *Date* _____

Agency _____ Phone # _____

Note: An authorized agent must complete an OBRA-I for all individuals who are seeking admission to a nursing facility or a DD Medicaid funded residential setting. An authorized agent must sign and date each applicable section of this form prior to an individual being admitted to a nursing facility. Signature by anyone other than an authorized agent of the State will be considered invalid. Payment for nursing facility services will not be made by the State of Illinois for individuals without an OBRA-I.

DEFINITIONS

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

“Activities of Daily Living” means eating, bathing, dressing, transferring, tilting, walking, and grooming.

Bank Nursing Facility Beds” means SLF providers that choose to participate by converting a distinct part of a nursing facility. Such facilities shall be allowed to retain the Certificate of Need for nursing beds that were converted.

“Complaint” means a phone call, letter or personal contact to the Department from a resident, family member or resident representative expressing a concern related to the health, safety or well-being of one or more SLF residents.

“Comprehensive Resident Assessment Instrument” or “RAN” means the Department designated resident assessment instrument designed for use in SLFs.

= “Department” means the Illinois Department of Healthcare and Family Services.

“Direct Care Staff” means staff which provides professional nursing services assistance with activities of daily living, or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual.

= “Distinct Part” means a separate building or an entire wing or other physically identifiable space of an existing facility licensed under the Nursing Home Care Act or the Hospital Licensing Act that is operated as an SLF distinguishable from the rest of the facility. The distinct part of a nursing facility will not be subject to provisions of the Nursing Home Care Act. The distinct part of a hospital will be subject to provisions of the Hospital Licensing Act while complying with provisions of this Subpart B. Distinct part does not include the conversion of an entire nursing facility or hospital.

= “Follow-up Care” means the response to, and documentation of, the service plan which is discussed with and agreed to by, the resident and/or the resident’s guardian. It may include physician referrals, revision of service plan to incorporate nursing services, health promotion counseling and teaching self care in meeting health needs.

“Freestanding Facility” means a separate building that is not part of an existing nursing facility or hospital. Freestanding facilities includes new construction, an existing building or conversion of an entire nursing facility or hospital into an SLF.

= “Licensed Nurse” means a person whose services are paid for by a SLF and who is licensed as a registered nurse, registered professional nurse, practical nurse or licensed practical nurse under the Nursing and Advanced Practice Nursing Act (225 ILCS 65).

“Medicaid” means the Department’s Medical Assistance Program.

“Medicaid Resident” means a person with a disability (as determined by the Social Security Administration) age 22 years and over or a person who is age 65 years and over, who has been determined eligible for Medicaid payment for SLF services. Eligibility for a person residing in a SLF shall be determined in accordance with 89 Ill. Adm. Code 120.10 and 120.61 (excluding subsection (f) of Section 120.61). Provisions for property transfers as described at 89 Ill. Adm. Code 120.387 shall apply to a person residing in an SLF. Provisions for the prevention of espousal impoverishment as described at 89 Ill. Adm. Code 120.379 shall apply to a person residing in an SLF.

“Medical Assistance Program” means the program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/Art. V) or successor programs and Title XIX of the Social Security Act (42 U.S.C. 1396) and related federal and State rules and regulations.

“Personal Allowance” means the \$90 minimum protected monthly amount that is retained by Medicaid-eligible residents for their personal use.

“Rehabilitated Nursing Facility” means the conversion of a distinct part of an existing nursing facility into a SLF.

= “Related Parties” means affiliates of an SLF; entities for which investments are accounted for by the equity method by the entire enterprise; trusts for the benefit of employees, such as pensions and profit-sharing trusts that are managed by or under the trusteeship of management; any general partner; management of the SLF; members of the immediate families of principal owners of the SLF or its management; and other parties with which the SLF may deal if one party controls or can significantly influence management or operating policies of the other to an extent that one of the transacting parties might be prevented from fully pursuing its own separate interests. An entity or person shall be deemed by the Department to be a related party if it can significantly influence management or operating policies of the transacting parties or if it has an ownership interest in one of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from fully pursuing its own separate interests.

“Resident” means a person living in a SLF, including Medicaid residents as defined in this Section, and individuals who are not eligible for Medicaid payment for SLF services.

“Room and Board” means the housing, utilities and meals provided under the resident contract. Unless otherwise specified in the resident contract, room and board does not include phone or cable charges.

“Services” refers to the personal and health care related services provided by an SLF pursuant to Section 146.230.

“Service Plan” means the written plan on the Department designated form that is developed for each resident based upon the annual comprehensive resident assessment or quarterly evaluation.

“SLF or Supportive Living Facility” means a residential setting that meets the requirements of this Subpart B.

“SSI” means Supplemental Security Income under Title XVI of the Social Security Act.

“Subcontractor” means any person who assumes any duties and responsibility from an SLF for the performance of SLF services pursuant to Section 146.230.