

initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor.

405 I AC 1-14.6-6 Active providers; rate review

Sec. 6. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative, and capital components, shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The normalized allowable per patient day cost for the direct care component, and the allowable per patient day costs for the therapy, indirect care, administrative, and capital components shall be established once per year for each provider based on the annual financial report.

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(c) Beginning October 1, 2007, the rate effective date of the annual rate review shall be the first October 1 that falls after the first calendar quarter following the provider's reporting year-end. Beginning July 1, 2008, the rate effective date of the annual rate review shall be the first July 1 that falls after the first calendar quarter following the provider's reporting year-end. The rate effective date of the annual rate review for all providers shall be July 1 of each year thereafter.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be:

- (1) updated each calendar quarter; and
- (2) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) When the number of nursing facility beds licensed by the Indiana State Department of Health is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate setting limitations shall be based on the newly licensed beds.

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the

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CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

<u>Effective Date</u>	<u>Midpoint Quarter</u>
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning July 1, 2011, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report used to establish a Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on the following minimum occupancy levels.

(1) For nursing facilities with less than fifty-one (51) beds, an occupancy rate equal to the greater of eighty-five percent (85%) or the provider's actual occupancy rate from the most recently completed historical period.

(2) For nursing facilities with greater than fifty (50) beds, an occupancy rate equal to the greater of ninety percent (90%), or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall reestablish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the applicable minimum occupancy requirement described in subsection (d), if both of the following conditions can be established to the satisfaction of the office:

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- (1) The provider demonstrates that its current resident census has:
 - (A) increased to the **applicable minimum occupancy level described in subsection (d)**, or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period; and
 - (B) remained at such level for not fewer than ninety (90) days.
- (2) The provider demonstrates that its resident census has:
 - (A) increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report; and
 - (B) remained at such level for not fewer than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%) or the provider's actual occupancy rate from the most recently completed historical period.

(g) **Except as provided for in subsection (h) below**, the CMIs contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

<u>RUG-III Group</u>	<u>RUG-III Code</u>	<u>CMI Table</u>
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85

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Special Care	SSC	1.75
Special Care	SSB	1.60
Special Care	SSA	1.51
Clinically Complex	CC2	1.33
Clinically Complex	CC1	1.27
Clinically Complex	CB2	1.14
Clinically Complex	CB1	1.07
Clinically Complex	CA2	0.95
Clinically Complex	CA1	0.87
Impaired Cognition	IB2	0.93
Impaired Cognition	IB1	0.82
Impaired Cognition	IA2	0.68
Impaired Cognition	IA1	0.62
Behavior Problems	BB2	0.89
Behavior Problems	BB1	0.77
Behavior Problems	BA2	0.67
Behavior Problems	BA1	0.54
Reduced Physical Functions	PE2	1.06
Reduced Physical Functions	PE1	0.96
Reduced Physical Functions	PD2	0.97
Reduced Physical Functions	PD1	0.87
Reduced Physical Functions	PC 2	0.83
Reduced Physical Functions	PC1	0.76

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Reduced Physical Functions	PB2	0.73
Reduced Physical Functions	PB1	0.66
Reduced Physical Functions	PA2	0.56
Reduced Physical Functions	PA1	0.50
Unclassifiable	BC1	0.48
Delinquent	BC2	0.48

(h) In place of the CMI's contained in subsection (g) above, beginning on January 1, 2010 and continuing thereafter, the CMI's contained in this subsection shall be used for purposes of determining the facility-average CMI for Medicaid residents that meet all the following conditions:

(1) The resident classifies into one of the following RUG-III groups:

- (A) PB2
- (B) PB1
- (C) PA2
- (D) PA1

(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to 10 or if there is not a BIMS score then a cognitive performance score (CPS) of:

- zero (0) – Intact;
- one (1) – Borderline Intact; or
- two (2) – Mild Impairment,

(3) based on an assessment of the resident's continence control as reported on the MDS, the resident is not experiencing occasional, frequent or complete incontinence control, and

(4) the resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.

(5) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments that are assigned a CMI in accordance with this subsection, then, for purposes of determining the facility's average CMI for Medicaid residents, the assessment or assessments shall be assigned 96% of the CMI associated with the RUG-III group determined in this subsection.

RUG-III Group	RUG-III Code	CMIs effective for the period following the effective date of this rule amendment		
		The first (1st) calendar quarter through the fourth (4th) calendar quarter	The fifth (5th) calendar quarter through the eighth (8th) calendar quarter	The ninth (9th) calendar quarter and thereafter
Reduced Physical Functions	PB2	0.48	0.41	0.30
Reduced Physical Functions	PB1	0.44	0.38	0.28
Reduced Physical Functions	PA2	0.38	0.32	0.24
Reduced Physical Functions	PA1	0.33	0.28	0.21

(i) The office or its contractor shall provide each nursing facility with the following:

(1) A preliminary CMI report that will:

- (A) serve as confirmation of the MDS assessments transmitted by the nursing facility; and
- (B) provide an opportunity for the nursing facility to correct and transmit any missing or incorrect MDS assessments.

The preliminary report will be provided by the twenty-fifth day of the first month following the end of a calendar quarter.

(2) Final CMI reports utilizing MDS assessments received by the fifteenth day of the second month following the end of a calendar quarter. These assessments received by the fifteenth day of the second month following the end of a calendar quarter will be utilized to establish the facility-average CMI and facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(j) The office will increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight (8) ventilator-dependent residents. Additional reimbursement shall be made to the facilities at a rate of eleven dollars and fifty cents (\$11.50) per Medicaid resident day. The additional reimbursement shall:

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- (1) be effective on the day the nursing facility provides inpatient services to more than eight (8) ventilator-dependent residents; and
- (2) remain in effect until the first day of the calendar quarter following the date the nursing facility provides inpatient services to eight (8) or fewer ventilator-dependent residents.

(k) Beginning July 1, 2003, through June 30, 2011, the office will increase Medicaid reimbursement to nursing facilities to encourage improved quality of care to residents based on the nursing home report card score. For purposes of determining the nursing home report card score rate add-on effective with this rule amendment, and each July 1 thereafter, the office or its contractor shall determine each nursing facility's report card score based on the latest published data as of the end of each state fiscal year. The nursing home report card score rate add-on shall be computed as described in the following table.

Nursing Home Report Card Score	Nursing Home Report Card Score Rate Add-on
0 - 82	\$5.75
83 - 265	$\$5.75 - [(Nursing\ Home\ Report\ Card\ Score - 82) \times \$0.03125]$
266 and above	\$0

Facilities that did not have a nursing home report card score published as of the most recently completed state fiscal year will receive a per patient day rate add-on equal to two dollars (\$2).

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(l) Beginning effective July 1, 2003, through June 30, 2011, the office will increase Medicaid reimbursement to nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as demonstrated by resident assessment data as of March 31 of each year. The additional Medicaid reimbursement shall equal twelve dollars (\$12.00) per Medicaid resident day in their SCU. Only facilities that meet the definition for a SCU for Alzheimer's disease or dementia shall be eligible to receive the additional reimbursement. Such additional Medicaid reimbursement shall be effective July 1 of the next state fiscal year.

(m) Nursing facilities that satisfy each of the four (4) conditions listed in this subsection shall qualify for a capital component rate add-on:

- (1) Twenty-five percent (25%) or more of its residents as of December 31, 2006, were under the chronological age of twenty-one (21) years of age.
- (2) According to the last health facility survey conducted by Indiana state department of health on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i).
- (3) The facility bedrooms accommodate no more than four (4) residents.
- (4) The facility bedrooms measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.

(n) The capital component rate add-on referenced in subsection (l) shall be calculated by dividing the qualifying facility's debt service associated with financing acquired exclusively to fund any capital costs incurred by the provider to come into compliance with 42 CFR 483.70(d)(1)(i), divided by total patient days from the facility's latest completed annual financial report. For purposes of this provision, debt service shall mean the total annual interest and principal payments required to be paid on any such financing arrangement or arrangements. The capital component rate add-on shall be determined following the provider's demonstration to the office of qualification for this provision, and shall become effective on the date the provider successfully completes the health facility survey of any new beds as conducted by the state department of health. The capital component rate add-on shall not be updated annually. Refinancing shall be recognized only when the interest rate is less than the original financing. The capital component rate add-on shall continue to apply until the associated financing has been fully paid.

(o) The capital component rate add-on described under subsection (n) shall be exempt from the capital component overall rate ceiling as determined under section 9(c)(4) of this rule.

(p) The capital component rate add-on described under subsection (n) shall be exempt from the maximum allowable increase as determined under section 23 of this rule.

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Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of computing the average historical cost of property of the median bed. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and operational use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

405 IAC 1-14.6-9 Rate components; rate limitations; profit add-on

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative, and capital components, plus a potential profit add-on payment **as defined calculated below**. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

- (1) The indirect care and capital components are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).
- (2) The therapy component is equal to the provider's allowable Medicaid per patient day direct therapy costs.
- (3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average CMI for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).
- (4) **The administrative component shall be equal to 100% of the average allowable cost of the median patient day.**

(b) The profit add-on payment will be calculated as follows:

- (1) For nursing facilities designated by the office as children's nursing facilities, the **allowed** direct care component profit add-on is equal to the profit add-on percentage contained in Table 1, times the difference (if greater than zero (0)) between:
 - (A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 1; minus
 - (B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 1
Children's Nursing Facilities

Effective Date	<u>Direct Care Profit Add-on Percentage</u>		<u>Direct Care Profit Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	30%	52%	110%	105%

- (2) For nursing facilities that are not designated by the office as children's nursing facilities, the **tentative** direct care component profit add-on **payment** is equal to the profit add-on percentage contained in Table 2, times the difference (if greater than zero (0)) between:
 - (A) the normalized average allowable cost of the median patient day for direct care costs times the facility average CMI for Medicaid residents times the profit ceiling percentage contained in Table 2; minus

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(B) the provider's normalized allowable per patient day costs times the facility average CMI for Medicaid residents.

Table 2
Non-Children's Nursing Facilities

Effective Date	<u>Direct Care Profit Add-on Percentage</u>		<u>Direct Care Profit Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	30%	0%	110%	105%

(C) For nursing facilities not designated by the office as children's nursing facilities, the allowed direct care component profit add-on payment is equal to the facility's tentative direct care component profit add-on payment times the applicable percentage contained in Table 3, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 3. – Allowed Direct Care Profit Add-On Percentage		
Nursing Home Report Card Score	Effective Dates	
	First (1 st) Full Calendar Quarter through Fourth (4 th) Full Calendar Quarter Following Rule Effective Date	Fifth (5 th) Full Calendar Quarter Following Rule Effective Date, and Thereafter
0 – 82	100%	100%
83 – 357	100% - [(Nursing Home Report Card Score - 82) x 0.36232%]	N/A
358 and greater	0%	N/A
83 – 279	N/A	100% - [(Nursing Home Report Card Score - 82) x 0.50505%]
280 and greater	N/A	0%

(D) In no event shall the allowed direct care profit add-on payment exceed ten percent (10%) of the average allowable cost of the median patient day.

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- (3) The **tentative indirect care component profit add-on payment** is equal to the profit add-on percentage contained in Table 4, times the difference (if greater than zero (0)) between:
- (A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 4; minus
 - (B) a provider's allowable per patient day cost.

Table 4

Effective Date	<u>Indirect Care Profit Add-on Percentage</u>		<u>Indirect Care Profit Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	60%	52%	105%	100%

- (C) The **allowed indirect care component profit add-on payment** is equal to the facility's tentative indirect care component profit add-on payment times the applicable percentage contained in Table 5, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Nursing Home Report Card Score	Effective Dates	
	First (1 st) Full Calendar Quarter through Fourth (4 th) Full Calendar Quarter Following Rule Effective Date	Fifth (5 th) Full Calendar Quarter Following Rule Effective Date, and Thereafter
0 – 82	100%	100%
83 – 357	100% - [(Nursing Home Report Card Score - 82) x 0.36232%]	N/A
358 and greater	0%	N/A
83 – 279	N/A	100% - [(Nursing Home Report Card Score - 82) x 0.50505%]
280 and greater	N/A	0%

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- (4) The tentative capital component profit add-on payment is equal to sixty percent (60%) times the difference (if greater than zero (0)) between:
- (A) the average allowable cost of the median patient day times the profit ceiling percentage contained in Table 6; minus
 - (B) a provider's allowable per patient day cost.

Table 6

Effective Date	Capital Component Profit Ceiling Percentage	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	100%	80%

- (C) The allowed capital component profit add-on payment is equal to the facility's tentative capital component profit add-on payment times the applicable percentage contained in Table 7, based on the facility's nursing home report card score as determined by the office or its contractor using the latest published data as of the end of each state fiscal year.

Table 7. – Allowed Capital Profit Add-On Percentage		
Nursing Home Report Card Score	Effective Dates	
	First (1 st) Full Calendar Quarter through Fourth (4 th) Full Calendar Quarter Following Rule Effective Date	Fifth (5 th) Full Calendar Quarter Following Rule Effective Date, and Thereafter
0 – 82	100%	100%
83 – 357	100% - [(Nursing Home Report Card Score – 82) x 0.36232%]	N/A
358 and greater	0%	N/A
83 – 279	N/A	100% - [(Nursing Home Report Card Score - 82) x 0.50505%]
280 and greater	N/A	0%

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(5) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate ceiling defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average CMI for Medicaid residents times the overall rate ceiling percentage in Table 8.

Table 8

Effective Date	<u>Direct Care Component Overall Rate Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	120%	110%

(2) The average allowable cost of the median patient day for indirect care costs times the overall rate ceiling percentage in Table 9.

Table 9

Effective Date	<u>Indirect Care Component Overall Rate Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	115%	100%

(3) The average allowable cost of the median patient day for capital-related costs times the overall rate ceiling percentage in Table 10.

Table 10

Effective Date	<u>Capital Component Overall Rate Ceiling Percentage</u>	
	July 1, 2003, through June 30, 2011	July 1, 2011, and after
Percentage	100%	80%

(4) For the therapy component, no overall rate component limit shall apply.

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(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider.

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

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