**Section 140.80 Hospital Provider Fund**

a) Purpose and Contents

1) The Hospital Provider Fund (Fund) was created in the State Treasury on February 3, 2004 (see 305 ILCS 5/5A-8). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Article 5A of the Code.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b);

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) Monies transferred from another fund in the State treasury;

E) All other monies received for the Fund from any other source, including interest earned on those monies.

b) Provider Assessments

1) Subject to Sections 5A-3, 5A-10 and 5A-15 of the Code, for State fiscal years 2009 through 2018, or as long as continued under Section 5A-16, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days; provided, however, the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12-5 of the Code, with that increase only taking effect upon the date that a State share for those payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this subsection (b)(1) shall be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this Section. For State fiscal years 2009 and after, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Subject to Sections 5A-3, 5A-10, and 5A-16of the Code, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2019 and 2020, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Section, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020*.* Subject to Sections 5A-3 and 5A-10, and in accordance with federal approval and P.A. 101-0650, for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount and the amount of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment as defined in subsection (l). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. For a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this subsection (b)(1).

2) In addition to any other assessments imposed under this Section, effective July 1, 2016 and semiannually thereafter through June 2018, or as provided in Section 5A-16, in addition to any federally required State share as authorized under subsection (b)(1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (l)(1).

3) Subject to Sections 5A-3, 5A-10, and 5A-15 of the Code for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue; provided, however, the multiplier of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12-5, with that increase only taking effect upon the date that a State share for those payments is required under federal law. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this subsection (b)(3) shall be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this Section. For the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012 and for State fiscal years 2013 through 2018, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to that data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Section, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020. Subject to Sections 5A-3 and 5A-10, for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however, for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount and the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (1). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 and 2022, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to that data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider. The data may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. For a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this subsection (b)(3).

c) Payment of Assessment Due

1) The inpatient assessment imposed by Section 5A-2 of the Code for State fiscal year 2009 through State fiscal year 2018, or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 14th State business day of each month. No installment payments of an inpatient assessment shall be due and payable, however, until after the Comptroller has issued the payments required under Section 5A-12.2 of the Code. Assessment payments postmarked on the due date will be considered as paid on time.

2) Except as provided in Section 5A-4(a-5) of the Code, the outpatient assessment imposed by subsection (b)(3) for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012 and for State fiscal year 2013 through State fiscal year 2018, or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 14th State business day of each month.

A) No installment payment of an outpatient assessment imposed by subsection (b)(3) shall be due and payable, however, until after:

i) the Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12.4 of the Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMMS), and the waiver under 42 CFR 433.68 for the assessment imposed by subsection (b) of this Section, if necessary, has been granted by CMMS; and

ii) the Comptroller has issued the payments required under Section 5A-12.4 of the Code.

B) Assessment payments postmarked on the due date will be considered as paid on time. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.4 of the Code and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b)(3) of this Section prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4 of the Code.

3) The assessment imposed under P.A. 101-0650 and Section 5A-2 of the Code for State fiscal year 2019 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 17th State business day of each month. The Department has discretion to establish a late date due to delays in payments being made to hospitals, as required by Section 5A-12.7 of the Code.

A) No installment payment of an assessment imposed by P.A. 101-0650 and Section 5A-2 of the Code shall be due and payable, however, until after:

i) The Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12.6 or 5A-12.7 of the Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and the waiver under 42 CFR 433.68 for the assessment imposed by P.A. 101-0650 and Section 5A-2 of the Code, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and

ii) The Comptroller and managed care organizations have issued the payments required under Section 5A-12.6 or 5A-12.7 of the Code.

B) Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.6 or 5A-12.7 of the Code and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b)(3) prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller and managed care organizations of the payments required under Section 5A-12.6 or 5A-12.7 of the Code.

4) Any assessment amount that is due and payable to the Department more frequently than once per calendar quarter shall be remitted to the Department by the hospital provider by means of electronic funds transfer. The Department may provide for remittance by other means if the amount due is less than $10,000 or electronic funds transfer is unavailable for this purpose.

5) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Notice Requirements, Penalty, and Maintenance of Records

1) The Department shall send a notice of assessment to every hospital provider subject to an assessment under subsection (b), except that no notice shall be sent for the outpatient assessment imposed under subsection (b)(3) until the Department receives written notice that the payment methodologies to hospitals required under Section 5A-12.4 of the Code has been approved and the waiver under 42 CFR 433.68, if necessary, has been granted by CMMS.

2) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate notice shall be sent for each hospital.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b), the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate or maintain a hospital, the person shall pay the assessment for the year as adjusted (to the extent not previously paid).

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b), upon notice by the Department, shall pay the assessment under subsection (d) as computed by the Department in installments on the due dates stated on the notices and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment notice. For State fiscal years 2009 through 2018, in the case of a hospital provider that did not conduct, operate or maintain a hospital in 2005, the inpatient assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Department. For the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, in the case of a hospital provider that did not conduct, operate or maintain a hospital in 2009, the outpatient assessment imposed under subsection (b)(3) shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Department. The assessment determination made by the Department is final.

1. Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the State fiscal year shall be annualized for the portion of the reporting period the hospital was operational (dividing the assessment due by the number of days the hospital was in operation and then multiplying the amount by 365). Information reported by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Notwithstanding any other provision in this Section, for State fiscal years 2019 through calendar year 2022, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in the year that is the basis of the calculation of the assessment under this Section, the assessment under subsection (b) for the State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

5) Notwithstanding any other provision in this Section, for State fiscal years 2019 through calendar year 2022, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in the year that is the basis of the calculation of the assessment under this Section, the assessment under subsection (b) for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

6) Change in Ownership and/or Operators. The full quarterly installment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1).

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion remaining unpaid on the last day of each monthly period thereafter, not to exceed 100% of the installment amount not paid on or before the due date. Waiver due to reasonable cause may include but is not limited to:

A) provider has not been delinquent on payment of an assessment due, within the last three calendar years from the time the delinquency occurs.

B) provider can demonstrate to the Department's satisfaction that a payment was made prior to the due date.

C) provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.

2) Within 30 days after the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any interest and penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Medicaid Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Hospitals

The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) The State delays payments to hospitals due to problems related to State cash flow; or

2) A cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Hospitals

In addition to the provisions of subsection (g), the Department may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c). The request must be received by the Department prior to the due date of the assessment.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) The provider has experienced an emergency that necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) would impose severe and irreparable harm to the clients served. Circumstances that may create these emergencies include, but are not limited to, the following:

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

ii) Cash flow problems encountered by a provider that are unrelated to Department technical system problems and that result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) The provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) A hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital (DSH) under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(2); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) A government-owned facility that meets the cash flow criterion under subsection (h)(1)(A)(ii).

iii) A hospital that has filed for Chapter 11 bankruptcy and that meets the cash flow criterion under subsection (h)(1)(A)(ii).

C) The provider must ensure that a delay of payment request, as defined under subsection (h)(3)(A), is received by the Department prior to the payment due date, and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date that is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) The ratio of current assets divided by current liabilities is greater than 2.0.

ii) Cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments that are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) The provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) The provider must sign an agreement with the Department that specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) Specific reasons for institution of the delayed payment provisions;

ii) Specific dates on which payments must be received and the amount of payment that must be received on each specific date described;

iii) The interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) A certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) A certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) Other terms and conditions that may be required by the Department.

2) A hospital that does not meet the above criteria may request a delayed payment schedule. The Department may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must ensure their request is received by the Department prior to the payment due date, in writing (telefax requests are acceptable) to the Bureau of Hospital and Provider Services. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) An explanation of the circumstances creating the need for the delayed payment provisions;

ii) Supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C), a denial of application to borrow the assessment as defined in subsection (h)(1)(D) and an explanation of the risk of irreparable harm to the clients; and

iii) Specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in that agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B), the penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and the penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E). The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C), is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B). Any waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E).

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions

The Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Department shall administer and enforce Sections 5A-1, 2, 3, 4, 5, 7, 8, 10, 12, 15, and 16 of the Code and collect the assessments and penalty assessments imposed under P.A. 101-0650 and Sections 5A-2 and 4 of the Code. The Department, its Director, and every hospital provider subject to assessment measured by occupied bed days shall have the following powers, duties and rights:

1) The Department may initiate either administrative or judicial proceedings, or both, to enforce the provisions of Sections 5A-1, 2, 3, 4, 5, 7, 8, 10, 12, 15 and 16 of the Code. Administrative enforcement proceedings initiated shall be governed by the Department's rules at 89 Ill. Adm. Code 104.200 through 104.330. Judicial enforcement proceedings initiated shall be governed by the rules of procedure applicable in the courts of this State.

2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than three years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Department and the hospital provider before the expiration of this limitation period.

3) Any unpaid assessment under P.A. 101-0650 and Section 5A-2 of the Code shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of the real property and improvements, the machinery and equipment, or the furniture or fixtures of any hospital that is subject to the provisions of Sections 5A-1, 2, 3, 4, 5, 7, 8, 10, 12, 15 and 16 of the Code, the seller or transferor shall pay the Department the amount of any assessment, assessment penalty, and interest (if any) due from it under P.A. 101-0650 and Sections 5A-2 and 4 of the Code up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of the asset shall be liable for the amount of the assessment, penalties and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that the assessment, penalty and interest have been paid or a certificate from the Department showing that no assessment, penalty or interest is due from the seller or transferor under P.A. 101-0650 and Sections 5A-2, 4 and 5 of the Code.

4) Payments under Section 5A-4 of the Code are not subject to the Illinois Prompt Payment Act [30 ILCS 540]. Credits or refunds shall not bear interest.

5) In addition to any other remedy provided for and without sending a notice of assessment liability, the Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Department to the hospital provider.

j) Exemptions

The following classes of providers are exempt from the assessment imposed under Section 5A-4 of the Code unless the exemption is adjudged to be unconstitutional or otherwise invalid:

1. 1) A hospital provider that is a State agency, a State university, or a county with a population of 3,000,000 or more.

2) A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit.

k) Nothing in Section 5A-4 of the Code shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before February 3, 2004.

l) Definitions

As used in this Section, unless the context requires otherwise:

1) "ACA Assessment Adjustment" means:

A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals authorized under Section 5A-12.5 of the Code and the adjustments authorized under Section 5A-12.2(t) of the Code to managed care organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals authorized under Section 5A-12.5 of the Code and the adjustments authorized under Section 5A-12.2(t) to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subsection (l)(1)(B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Code Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subsection (l)(1)(A).

C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals authorized under Section 5A-12.5 of the Code and the adjustments authorized under Section 5A-12.2(t) of the Code to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subsection (l)(1)(C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Code Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subsection (l)(1)(B).

D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals authorized under Section 5A-12.5 of the Code and the adjustments authorized under Section 5A-12.2(t) of the Code to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

i) the amount calculated under this subsection (l)(1)(D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Code Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subsection (l)(1)(C); and

ii) the amount calculated under this subsection (l)(1)(D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under Section 5A-12.5(b) of the Code.

2) "Assessment Adjustment" means, for the period of July 1, 2020 through December 31, 2020, the product of .3853 multiplied by the total of the actual payments made under Section 5A-12.7(c) through (k) of P.A. 101-0650 attributable to that period, less the total of the assessment imposed under subsections (b)(1) and (b)(3) of this Section for the period. For each calendar quarter beginning on and after January 1, 2021, the product of .3853 multiplied by the total of the actual payments made under Section 5A-12.7(c) through (k) of P.A. 101-0650 attributable to the period, less the total of the assessment imposed under subsections (b)(1) and (b)(3) of this Section for that period.

3) "CMMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

4) "Code" means the Illinois Public Aid Code [305 ILCS 5].

5) "Department" means the Illinois Department of Healthcare and Family Services.

6) "Fund" means the Hospital Provider Fund.

7) "HCRIS" means the federal Centers for Medicare and Medicaid Services Healthcare Cost Report Information System.

8) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

9) "Hospital Provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

10) "Inpatient Gross Revenue" means total inpatient gross revenue, as reported on the HCRIS Worksheet C, Part 1, Column 6, Line 101, less the sum of the following lines (including any subset lines of these lines):

A) Line 34: Skilled Nursing Facility.

B) Line 35: Other Nursing Facility.

C) Line 35.01: Intermediate Care Facility for the Mentally Retarded.

D) Line 36: Other Long Term Care.

E) Line 45: PBC Clinical Laboratory Services – Program Only.

F) Line 60: Clinic.

G) Line 63: Other Outpatient Services.

H) Line 64: Home Program Dialysis.

I) Line 65: Ambulance Services.

J) Line 66: Durable Medical Equipment – Rented.

K) Line 67: Durable Medical Equipment – Sold.

L) Line 68: Other Reimbursable.

11) "Medicare Bed Days" means, for each hospital, the sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services. Medicare bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

12) "Medicare Gross Inpatient Revenue" means the sum of the following:

A) The sum of the following lines from the HCRIS Worksheet D-4, Column 2 (excluding the Medicare gross revenue attributable to the routine services provided to patients in a psychiatric hospital, a rehabilitation hospital, a distinct part psychiatric unit, a distinct part rehabilitation unit or swing beds):

i) Line 25: Adults and Pediatrics.

ii) Line 26: Intensive Care Unit.

iii) Line 27: Coronary Care Unit.

iv) Line 28: Burn Intensive Care Unit.

v) Line 29: Surgical Intensive Care Unit.

vi) Line 30: Other Special Care Unit.

B) From Worksheet D-4, Column 2, the amount from Line 103 less the sum of Lines 60, 63, 64, 66, 67 and 68 (and any subset lines of these lines).

C) The amount from Worksheet D-6, Part 3, Column 3, Line 53.

13) "Medicare Gross Outpatient Revenue" means the amount from the HCRIS Worksheet D, Part V, Line 101, Columns 5, 5.01, 5.02, 5.03 and 5.04 less the sum of Lines 45, 60, 63, 64, 65, 66 and 67 (and any subset lines of these lines).

14) "Occupied Bed Days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding beds classified as long term care beds and assessed a licensed bed fee during calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

15) "Outpatient Gross Revenue" (prior to State fiscal year 2019 from Medicare 2552-96 cost reports) means, for each hospital, its total gross charges attributed to outpatient services as reported on the Medicare cost report at Worksheet C, Part I, Column 7, Line 101 less the sum of lines 45, 60, 63, 64, 65, 66, 67 and 68 (and any subset lines of these lines).

16) "Outpatient Gross Revenue" (for State fiscal year 2019 and thereafter from Medicare 2552-10 cost reports) means, for each hospital, its total gross charges attributed to outpatient services as reported on the Medicare cost report at Worksheet C, Part I, Column 7, Line 200 less the sum of lines 61, 90, 94, 95, 96, 97, 99, 100, 101, 115, 116, and 117 (and any subset lines of these lines).

(Source: Amended at 44 Ill. Reg. 19713, effective December 11, 2020)