**Section 140.84 Long Term Care Provider Fund**

a) Purpose and Contents

1) The Long Term Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see Section 5B-8 of the Code). 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 Sections 5B-2 and 5B-8 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 from the Fund;

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

D) All other monies received for the Fund from any other source, including interest earned thereon; and

E) All monies transferred from the Tobacco Products Tax Act [35 ILCS 143].

b) License Fee and Provider Assessment

1) Beginning on July 1, 1993, and ending on June 30, 2022, a nursing home license fee is imposed upon each nursing home provider in an amount equal to $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. All nursing beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(11) will be used to calculate the licensed nursing bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Changes in the number of licensed nursing beds will be reported to the Department quarterly, as described in subsection (d)(1). The Department reserves the right to audit the reported data.

2) Beginning July 1, 2011 and ending on June 30, 2022, an assessment is imposed upon each long term care provider in an amount equal to $6.07 times the number of occupied bed days due and payable each month. This assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider.

3) Beginning July 1, 2022, an assessment is imposed upon each long-term care provider in an amount varying with the number of paid Medicaid resident days per annum in the facility with the following schedule of occupied bed tax amounts. This assessment is due and payable each month and shall be construed as a tax but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider.

A) The tax shall follow the schedule below and be rebased by the Department on an annual basis.

i) 0-5,000 paid Medicaid resident days per annum, $10.67.

ii) 5,001-15,000 paid Medicaid resident days per annum, $19.20.

iii) 15,001-35,000 paid Medicaid resident days per annum, $22.40.

iv) 35,001-55,000 paid Medicaid resident days per annum, $19.20.

v) 55,001-65,000 paid Medicaid resident days per annum, $13.86.

vi) 65,001+ paid Medicaid resident days per annum, $10.67.

vii) Any non-profit nursing facilities without Medicaid-certified beds, $7 per occupied bed day.

B) The Department shall publish each facility's rebased tax rate according to the schedule in this subsection 30 days prior to the beginning of the 6-month period beginning July 1, 2022 and thereafter 30 days prior to the beginning of each calendar year which shall incorporate the number of paid Medicaid days used to determine each facility's rebased tax rate. The notice shall include the number of paid Medicaid days broken down by days paid by each Managed Care Organization, Fee for Service, and each contracted MMAI plan. The notice shall also specify the dates of service used for the determination and the date on which the data was queried.

C) For each new calendar year and for the 6-month period beginning July 1, 2022, a facility's paid Medicaid resident days per annum shall be determined using the Department's Medicaid Management Information System to include Medicaid resident days for the year ending 9 months earlier. The Department will query the MMIS to make this determination as late as is reasonably possible subject to the publication deadline in subsection (b)(3)(B) and will adjust the number of paid Medicaid resident days per annum, if necessary, using the Department’s nursing home provider tax database to more accurately distinguish Medicare and Medicaid payment. The number of paid Medicaid days shall also include hospice days and provisional days, if applicable.

4) Appeals of Tax Rate Determinations

A) Appeals of tax rate determinations shall be submitted in writing to the Department. Appeals received within 30 days after tax rate notification shall, if upheld, be made effective as of the beginning of the tax year. The effective date of all upheld appeals filed after the initial 30-day period shall be the first day of the month after the date the complete appeal was received. Payments shall be made based on the Department's determination pending the results of the appeal.

B) Appeals of tax rate determinations under this Section shall be submitted in writing to the Chief, Bureau of Long Term Care. The Department shall rule on all appeals within 120 days after the date of appeal, except that if the Department requires additional information from the facility the period shall be extended until such time as the information is provided. Appeals for any tax year must be filed before the close of the first quarter of the tax year. Amounts owed as a result of an upheld appeal shall be applied as a credit towards future taxes owed and payable.

c) Payment of License Fee and Assessment Due

1) The license fee described in subsection (b) shall be due and payable in quarterly installments, on September 10, December 10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be considered as paid on time.

2) The assessment described in subsection (b) shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has its payments from the State delayed, due to problems related to State cash flow, may request an extension on the due date for payment pursuant to subsection (b) and shall pay each extended assessment payment within 30 days after each reimbursement for services by the Department.

A) The Department shall provide for an electronic submission process for each long term care facility to report the number of occupied bed days of the long term care facility for the reporting period and other reasonable information the Department requires for the administration of its responsibilities. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long term care facilities.

B) Beginning July 1, 2013, a separate electronic submission shall be completed for each long term care facility in this State operated by a long term care provider. The Department shall prepare an assessment, based on the reported occupied beds, and will bill the facility stating the amount due and payable each month and submit it to each long term care facility via an electronic process. Each assessment payment shall be accompanied by a copy of the assessment bill sent to the long term care facility by the Department.

C) The provider assessment imposed by this Section shall not be due and payable until after the Department notifies the long term care providers, in writing, that the payment methodologies to long term care providers required under Section 5-5.4 of the Public Aid Code have been approved and the waivers under 42 CFR 433.68, if necessary, have been granted by CMMS.

3) 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.

4) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code [55 ILCS 5] may meet their license fee or assessment obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee or assessment. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after the final approval of the county budget;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee or assessment payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) On or before the due dates described in subsection (c)(1), each nursing home provider subject to a license fee under subsection (b) shall file a report with the Department reflecting any changes in the number of licensed nursing beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b), all changes in licensed nursing beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed nursing beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Healthcare and Family Services with the licensed nursing bed change form.

2) After December 31 of each year, and on or before March 31 of the succeeding year, every long term care provider subject to assessment under subsection (c)(2) shall file a report with the Department. The report shall be in a form and manner prescribed by the Department and shall state the revenue received by the long term care provider, reported in such categories as may be required by the Department, and other reasonable information the Department requires for the administration of its responsibilities.

3) If a provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice president, secretary or treasurer or by its properly authorized agent.

4) If the provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee or assessment imposed in subsection (b) a penalty fee equal to 25% of the assessment or license fee imposed for the year. After July 1, 2013, no penalty will be assessed if the Department has not established a process for the electronic submission of information as it pertains to the assessment.

5) Every provider subject to a license fee or assessment under subsection (b) shall keep records and books that will permit the determination of licensed nursing bed days on a quarterly basis and occupied beds on a monthly basis. All such books and records shall be maintained for a minimum of three years following the filing date of each report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

6) Amended License Fee and Assessment Reports. With the exception of amended license fee or assessment reports filed in accordance with this subsection (d)(6), an amended license fee report or monthly assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual license fee or assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

7) Reconsideration of Adjusted License Fee or Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the license fee or assessment was due, changes the license fee or assessment liability of a provider, the provider may request a review or reconsideration of the adjusted license fee or assessment within 30 days after the Department's notification of the change in license fee or assessment liability. Requests for reconsideration of the license fee or assessment adjustment shall not be considered if those requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

8) Effective January 1, 2023, all providers operating or maintaining a long-term care facility shall notify the Department of all individual owners and any individuals or organizations that are part of a limited liability company with ownership of that facility, and the percentage ownership of each owner. This ownership reporting requirement does not include individual shareholders in a publicly held corporation. Submission of the information as part of the Department's cost reporting requirements shall satisfy this request.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the period in which the license fee or assessment is being paid and the closure date has been set. A provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b) of this Section, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the period in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting period and shall be submitted with the final quarterly license fee or monthly assessment payment. Example: A facility is set to close on September 24. On or before the due date for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of operation (July 1 through September 24) and the corresponding quarterly license fee payment.

2) Cessation of business after the monthly or quarterly due date. A provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b), and for which closure occurs after the due date for the reporting period, but prior to the last day of the reporting period, shall file an amended final report with the Department within 30 days after the closure date. The amended report will reflect the number of days the facility was operational during the reporting period and the revised license fee or assessment amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes on December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27) must be filed with the Department.

3) Cessation of business prior to the monthly or quarterly due date. A provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee or assessment imposed under subsection (b), and for which closure occurs prior to the due date for the reporting period, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the reporting period and the corresponding final license fee and assessment amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee and assessment due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

4) Commencing of business during the fiscal year in which the license fee or assessment is being paid. A provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee or assessment imposed under subsection (b) shall file an initial report for the reporting period in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee and assessment under subsection (c). In determining the annual assessment amount for the provider, the Department shall develop hypothetical annualized occupied bed projections based upon geographic location and facility. The assessment determination made by the Department is final.

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

6) Upon request, the Department will share with a potential buyer of a facility information on outstanding assessments and penalties owed by that facility.

f) Penalties

1) Any provider that fails to pay the full amount of a license fee or assessment when due, or fails to report a change in licensed nursing beds approved by the Department of Public Health prior to the due date of the license fee or assessment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the license fee or assessment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100% of the installment or assessment amount not paid on or before the due date. Reasonable cause may include but is not limited to:

1. A) a provider who has not been delinquent on payment of a license fee or assessment due, within the last three calendar years from the time the delinquency occurs;

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

C) that the provider is a new owner/operator and the late payment occurred in the reporting period 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 providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee or assessment, including any 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 provider fails to comply with an agreement, the Department reserves the right to recover any outstanding license fee, assessment, interest and penalty by recouping the amount or a portion thereof from the provider'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 provider two times in a fiscal year may be cause for termination from the 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 provider 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 license fee or assessment 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 Facilities

The Department may establish delayed payment of fees/assessment and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities 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 facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment – Individual Facilities

In addition to the provisions of subsection (g), the Department may delay license fees or assessments for individual facilities 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 period or month following the quarter in which the license fee or the assessment payment was to have been received by the Department as described in subsection (c). The Department may not deny a request for delay of payment of the assessment imposed in subsection (b) if the provider has not been paid due to problems related to State cash flow for services provided during the month in which the assessment is levied. 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 shall be made only to qualified facilities who meet all of the following requirements:

A) the facility 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), (f)(2) and (f)(3) would impose severe and irreparable harm to the clients served. Circumstances which may create such 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 facility's ability to provide further services to clients is severely impaired;

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

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85% or more of their residents must be eligible for public assistance;

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

iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion under subsection (h)(1)(A)(ii).

C) the facility must ensure that a delay of payment request, as defined under subsection (h)(3)(A), is received by the Department and the request must include a Cash Position Statement that is based upon current assets, current liabilities and other data for a date which 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 license fee or 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 license fee 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;

iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee or assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee or 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 facility 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 facility 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 facility that does not meet the criteria in subsection (h)(1) may request a delayed payment schedule, prior to the due date. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. 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, facilities 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 Rate Development and Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of 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 license fee or 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 facility.

B) The facility shall be notified by the Department, in writing prior to the license fee or 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 facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility'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 or month as it pertains to assessment, unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such 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 facility meets the criteria in subsections (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E).

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility 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 delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions

The Department shall administer and enforce Section 5B-7 of the Code, and collect the license fees, assessments, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under ROTA.

j) Nothing in Section 5B of the Code shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.

k) Definitions

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

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

2) "Fund" means the Long Term Care Provider Fund.

3) "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.

4) "Licensed nursing bed days" means, with respect to a nursing home provider, the sum for all nursing beds, with the exception of swing-beds, as described in subsection (k)(11), of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act [210 ILCS 45] or the Hospital Licensing Act [210 ILCS 85].

5) "Long term care facility" means a nursing facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act or the ID/DD Community Care Act [210 ILCS 47], including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and a part of a hospital in which skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long term care facility" does not include a facility operated by a State agency or operated solely as an intermediate care facility for the developmentally disabled within the meaning of Title XIX of the Social Security Act.

6) "Long term care provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility or a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVII or XIX of the Social Security Act. 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.

7) "Nursing home" means a skilled nursing or intermediate long term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning on Title XIX of the Social Security Act.

8) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long term care services; or a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act.

9) "Occupied bed days" shall be computed separately for each long term care facility operated or maintained by a long term care provider, and means the sum, for all beds, of the number of days during the month on which each bed was occupied by a resident, other than a resident for whom Medicare Part A is primary payer. For a resident whose care is covered by the Medicare-Medicaid Alignment Initiative demonstration, Medicare Part A is considered the primary payer to the extent Medicare would have been the primary payer in the absence of the demonstration.

10) "Person" means, in addition to natural persons, 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.

11) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Centers for Medicare and Medicaid Services to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 46 Ill. Reg. 19641, effective November 28, 2022)