AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. The Illinois Administrative Procedure Act is amended by adding Section 5-45.21 as follows:

(5 ILCS 100/5-45.21 new)

Sec. 5-45.21. Emergency rulemaking; Department of Healthcare and Family Services. To provide for the expeditious and timely implementation of the changes made to Articles 5 and 5B of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly, emergency rules implementing the changes made to Articles 5 and 5B of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed on September 30, 2022.

Section 5. The Illinois Public Aid Code is amended by changing Sections 5-5.2, 5-5.8, 5B-2, 5B-4, 5B-5, 5B-8, and 5E-10 and by adding Section 5E-20 as follows:

(305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services.

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(c) (Blank). ~~Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Resource Utilization Groups (RUGs) has been fully operationalized, which shall take effect for services provided on or after January 1, 2014.~~

(c-1) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Patient Driven Payment Model (PDPM) has been fully operationalized, which shall take effect for services provided on or after the implementation of the PDPM reimbursement system begins. For the purposes of this amendatory Act of the 102nd General Assembly, the implementation date of the PDPM reimbursement system and all

related provisions shall be July 1, 2022 if the following conditions are met: (i) the Centers for Medicare and Medicaid Services has approved corresponding changes in the reimbursement system and bed assessment; and (ii) the Department has filed rules to implement these changes no later than June 1, 2022. Failure of the Department to file rules to implement the changes provided in this amendatory Act of the 102nd General Assembly no later than June 1, 2022 shall result in the implementation date being delayed to October 1, 2022.

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model ~~RUC-IV 48 grouper model~~, which shall be referred to as the PDPM ~~RUGs~~ reimbursement system, taking effect July 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services ~~January 1, 2014~~, shall be based on the following:

(1) The methodology shall be resident-centered ~~resident driven~~, facility-specific, cost-based, and based on guidance from the Centers for Medicare and Medicaid Services ~~and cost based~~.

(2) Costs shall be annually rebased and case mix index quarterly updated. The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment

Reference Date of the Minimum Data Set (MDS).

(3) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30, 2012 shall be included, except no adjuster shall be lower than 1.06 ~~1.0~~.

(4) PDPM nursing case mix indices in effect on March 1, 2022 ~~Case mix index~~ shall be assigned to each resident class at no less than 0.7858 of ~~based on~~ the Centers for Medicare and Medicaid Services PDPM unadjusted case mix values, in effect on March 1, 2022, ~~staff time measurement study in effect on July 1, 2013,~~ utilizing an index maximization approach.

(5) The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).

(6) The Department shall establish a variable per diem staffing add-on in accordance with the most recent available federal staffing report, currently the Payroll Based Journal, for the same period of time, and if applicable adjusted for acuity using the same quarter's MDS. The Department shall rely on Payroll Based Journals provided to the Department of Public Health to make a determination of non-submission. If the Department is notified by a facility of missing or inaccurate Payroll Based Journal data or an incorrect calculation of staffing, the Department must make a correction as soon as

the error is verified for the applicable quarter.

Facilities with at least 70% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $14.88. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $14.88, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $23.80. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $29.75. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $35.70. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. Beginning April 1, 2023, no nursing facility's variable staffing per diem add-on shall be reduced by more than 5%

in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% of the staffing indicated by the STRIVE study. No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

(7) For dates of services beginning July 1, 2022, the PDPM nursing component per diem for each nursing facility shall be the product of the facility's (i) statewide PDPM nursing base per diem rate, $92.25, adjusted for the facility average PDPM case mix index calculated quarterly and (ii) the regional wage adjuster, and then add the Medicaid access adjustment as defined in (e-3) of this Section. Transition rates for services provided between July 1, 2022 and October 1, 2023 shall be the greater of the PDPM nursing component per diem or:

(A) for the quarter beginning July 1, 2022, the RUG-IV nursing component per diem;

(B) for the quarter beginning October 1, 2022, the sum of the RUG-IV nursing component per diem multiplied by 0.80 and the PDPM nursing component per diem multiplied by 0.20;

(C) for the quarter beginning January 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.60 and the PDPM nursing component per

diem multiplied by 0.40;

(D) for the quarter beginning April 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.40 and the PDPM nursing component per diem multiplied by 0.60;

(E) for the quarter beginning July 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.20 and the PDPM nursing component per diem multiplied by 0.80; or

(F) for the quarter beginning October 1, 2023 and each subsequent quarter, the transition rate shall end and a nursing facility shall be paid 100% of the PDPM nursing component per diem.

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate.

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

(B) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by subsection (A).

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph

(5).

(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:

(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).

(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.

(D) The sum of the products calculated for each nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.

(3) The Statewide RUG-IV nursing base per diem rate:

(A) on January 1, 2014 shall be the quotient of the paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2); ~~and~~

(B) on and after July 1, 2014 and until July 1, 2022, shall be the amount calculated under

subparagraph (A) of this paragraph (3) plus $1.76; and ~~.~~

(C) beginning July 1, 2022 and thereafter, $7 shall be added to the amount calculated under subparagraph (B) of this paragraph (3) of this Section.

(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.

(5) Nursing facilities designated as of July 1, 2012 by the Department as "Institutions for Mental Disease" shall be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.

(e) Beginning July 1, 2014, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to the RUGS methodology for dates of service on and after July 1, 2014:

(1) $0.63 for each resident who scores in I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

(2) $2.67 for each resident who scores either a "1" or "2" in any items S1200A through S1200I and also scores in RUG groups PA1, PA2, BA1, or BA2.

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 and

ending September 30, 2023, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. ~~Transition rates for services provided between January 1, 2014 and December 31, 2014 shall be as follows:~~

~~(1) The transition RUG IV per diem nursing rate for nursing homes whose rate calculated in this subsection (c-2) is greater than the nursing component rate in effect July 1, 2012 shall be paid the sum of:~~

~~(A) The nursing component rate in effect July 1, 2012; plus~~

~~(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.88.~~

~~(2) The transition RUG IV per diem nursing rate for nursing homes whose rate calculated in this subsection (c-2) is less than the nursing component rate in effect July 1, 2012 shall be paid the sum of:~~

~~(A) The nursing component rate in effect July 1, 2012; plus~~

~~(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.13.~~

(e-3) A Medicaid Access Adjustment of $4 adjusted for the facility average PDPM case mix index calculated quarterly shall be added to the statewide PDPM nursing per diem for all facilities with annual Medicaid bed days of at least 70% of all occupied bed days adjusted quarterly. For each new calendar year and for the 6-month period beginning July 1, 2022, the percentage of a facility's occupied bed days comprised of Medicaid bed days shall be determined by the Department quarterly. This subsection shall be inoperative on and after January 1, 2028.

(f) (Blank). ~~Notwithstanding any other provision of this Code, on and after July 1, 2012, reimbursement rates associated with the nursing or support components of the current nursing facility rate methodology shall not increase beyond the level effective May 1, 2011 until a new reimbursement system based on the RUGs IV 48 grouper model has been fully operationalized.~~

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) (Blank); ~~Individual nursing rates for residents classified in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter ending March 31, 2012 shall be reduced by 10%;~~

(2) (Blank); ~~Individual nursing rates for residents~~

~~classified in all other RUG-IV groups shall be reduced by 1.0%;~~

(3) Facility rates for the capital and support components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(j) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish, through June 30, 2022 a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate

taking into account federal matching funds for the purpose of addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning July 1, 2022, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (6) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services ~~and taking into account subsection (i)~~.

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be used to increase each facility's rate by an equal

percentage.

~~To implement item (i) in this subsection, facilities shall file quarterly reports documenting compliance with its annually approved staffing plan, which shall permit compliance with Section 3-202.05 of the Nursing Home Care Act. A facility that fails to meet the benchmarks and dates contained in the plan may have its add-on adjusted in the quarter following the quarterly review. Nothing in this Section shall limit the ability of the facility to appeal a ruling of non-compliance and a subsequent reduction to the add-on. Funds adjusted for noncompliance shall be maintained in the Long-Term Care Provider Fund and accounted for separately. At the end of each fiscal year, these funds shall be made available to facilities for special staffing projects.~~

~~In order to provide for the expeditious and timely implementation of the provisions of Public Act 101-10, emergency rules to implement any provision of Public Act 101-10 may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The agency shall simultaneously file emergency rules and permanent rules to ensure that there is no interruption in administrative guidance. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection, and the effective period may continue through June 30, 2021. The 24-month limitation on the adoption of emergency rules does~~

~~not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.~~

(k) During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must consider a revised reimbursement methodology that takes into account transparency, accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) The Department shall establish per diem add-on payments to improve the quality of care delivered by facilities, including:

(1) Incentive payments determined by facility performance on specified quality measures in an initial amount of $70,000,000. Nothing in this subsection shall be construed to limit the quality of care payments in the aggregate statewide to $70,000,000, and, if quality of

care has improved across nursing facilities, the Department shall adjust those add-on payments accordingly. The quality payment methodology described in this subsection must be used for at least State Fiscal Year 2023. Beginning with the quarter starting July 1, 2023, the Department may add, remove, or change quality metrics and make associated changes to the quality payment methodology as outlined in subparagraph (E). Facilities designated by the Centers for Medicare and Medicaid Services as a special focus facility or a hospital-based nursing home do not qualify for quality payments.

(A) Each quality pool must be distributed by assigning a quality weighted score for each nursing home which is calculated by multiplying the nursing home's quality base period Medicaid days by the nursing home's star rating weight in that period.

(B) Star rating weights are assigned based on the nursing home's star rating for the LTS quality star rating. As used in this subparagraph, "LTS quality star rating" means the long-term stay quality rating for each nursing facility, as assigned by the Centers for Medicare and Medicaid Services under the Five-Star Quality Rating System. The rating is a number ranging from 0 (lowest) to 5 (highest).

(i) Zero-star or one-star rating has a weight of 0.

(ii) Two-star rating has a weight of 0.75.

(iii) Three-star rating has a weight of 1.5.

(iv) Four-star rating has a weight of 2.5.

(v) Five-star rating has a weight of 3.5.

(C) Each nursing home's quality weight score is divided by the sum of all quality weight scores for qualifying nursing homes to determine the proportion of the quality pool to be paid to the nursing home.

(D) The quality pool is no less than $70,000,000 annually or $17,500,000 per quarter. The Department shall publish on its website the estimated payments and the associated weights for each facility 45 days prior to when the initial payments for the quarter are to be paid. The Department shall assign each facility the most recent and applicable quarter's STAR value unless the facility notifies the Department within 15 days of an issue and the facility provides reasonable evidence demonstrating its timely compliance with federal data submission requirements for the quarter of record. If such evidence cannot be provided to the Department, the STAR rating assigned to the facility shall be reduced by one from the prior quarter.

(E) The Department shall review quality metrics used for payment of the quality pool and make recommendations for any associated changes to the methodology for distributing quality pool payments in

consultation with associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and payors. The Department may establish, by rule, changes to the methodology for distributing quality pool payments.

(F) The Department shall disburse quality pool payments from the Long-Term Care Provider Fund on a monthly basis in amounts proportional to the total quality pool payment determined for the quarter.

(G) The Department shall publish any changes in the methodology for distributing quality pool payments prior to the beginning of the measurement period or quality base period for any metric added to the distribution's methodology.

(2) Payments based on CNA tenure, promotion, and CNA training for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. As used in this paragraph, "CNA" means a certified nursing assistant as that term is described in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, and Section 3-206 of the MC/DD Act. The Department shall establish, by rule, payments to nursing facilities equal to Medicaid's share of the tenure wage increments

specified in this paragraph for all reported CNA employee hours compensated according to a posted schedule consisting of increments at least as large as those specified in this paragraph. The increments are as follows: an additional $1.50 per hour for CNAs with at least one and less than 2 years' experience plus another $1 per hour for each additional year of experience up to a maximum of $6.50 for CNAs with at least 6 years of experience. For purposes of this paragraph, Medicaid's share shall be the ratio determined by paid Medicaid bed days divided by total bed days for the applicable time period used in the calculation. In addition, and additive to any tenure increments paid as specified in this paragraph, the Department shall establish, by rule, payments supporting Medicaid's share of the promotion-based wage increments for CNA employee hours compensated for that promotion with at least a $1.50 hourly increase. Medicaid's share shall be established as it is for the tenure increments described in this paragraph. Qualifying promotions shall be defined by the Department in rules for an expected 10-15% subset of CNAs assigned intermediate, specialized, or added roles such as CNA trainers, CNA scheduling "captains", and CNA specialists for resident conditions like dementia or memory care or behavioral health.

(m) The Department shall work with nursing facility

industry representatives to design policies and procedures to permit facilities to address the integrity of data from federal reporting sites used by the Department in setting facility rates.

(Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19; 102-77, eff. 7-9-21; 102-558, eff. 8-20-21.)

(305 ILCS 5/5-5.8) (from Ch. 23, par. 5-5.8)

Sec. 5-5.8. Report on nursing home reimbursement. The Illinois Department shall report annually to the General Assembly, no later than the first Monday in April of 1982, and each year thereafter, in regard to:

(a) the rate structure used by the Illinois Department to reimburse nursing facilities;

(b) changes in the rate structure for reimbursing nursing facilities;

(c) the administrative and program costs of reimbursing nursing facilities;

(d) the availability of beds in nursing facilities for public aid recipients; ~~and~~

(e) the number of closings of nursing facilities, and the reasons for those closings; and ~~.~~

(f) for years beginning 2025 and thereafter, drawing on all available information that evaluates, to the extent possible, nursing facility costs and revenue, including a focus on the period of initial implementation of the

payments and programs authorized in this Act.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

(Source: P.A. 100-1148, eff. 12-10-18.)

(305 ILCS 5/5B-2) (from Ch. 23, par. 5B-2)

Sec. 5B-2. Assessment; no local authorization to tax.

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 through June 30, 2022, or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1), whichever is later, 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. Notwithstanding any provision of any other Act to the contrary, 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.

(a-1) For the privilege of engaging in the occupation of long-term care provider for each occupied non-Medicare bed day, 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. The tax shall follow the schedule below and be rebased by the Department on an annual basis. The Department shall publish each facility's rebased tax rate according to the schedule in this Section 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.

(1) 0-5,000 paid Medicaid resident days per annum, $10.67.

(2) 5,001-15,000 paid Medicaid resident days per annum, $19.20.

(3) 15,001-35,000 paid Medicaid resident days per annum, $22.40.

(4) 35,001-55,000 paid Medicaid resident days per annum, $19.20.

(5) 55,001-65,000 paid Medicaid resident days per annum, $13.86.

(6) 65,001+ paid Medicaid resident days per annum, $10.67.

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

Notwithstanding any provision of any other Act to the contrary, 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.

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.

(b) Nothing in this amendatory Act of 1992 shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon long-term care providers or the occupation of long-term care provider, or a tax or assessment measured by the income or earnings or occupied bed days of a long-term care provider.

(c) The assessment imposed by this Section shall not be due and payable, however, until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.2 ~~5-5.4~~ of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and that the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of

Health and Human Services.

(Source: P.A. 96-1530, eff. 2-16-11; 97-10, eff. 6-14-11; 97-584, eff. 8-26-11.)

(305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

Sec. 5B-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5B-2 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 delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois 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 assessment.

(a-5) The Illinois Department shall provide for an electronic submission process for each long-term care facility to report at a minimum the number of occupied bed days of the long-term care facility for the reporting period and other reasonable information the Illinois Department requires for

the administration of its responsibilities under this Code. 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 Illinois Department shall provide a self-reporting notice of the assessment form that the long-term care facility completes for the required period and submits with its assessment payment to the Illinois Department. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

(b) The Illinois Department is authorized to establish delayed payment schedules for long-term care providers that are unable to make assessment payments when due under this Section due to financial difficulties, as determined by the Illinois Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under this Article if the long-term care provider has not been paid by the State or the Medicaid managed care organization for services provided during the month on which the assessment is levied ~~or the Medicaid managed care organization has not been paid by the State~~.

(c) If a long-term care provider fails to pay the full amount of an assessment payment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty

assessment equal to the lesser of (i) 5% of the amount of the assessment payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments. Payment cycles of longer than 60 days shall be one factor the Director takes into account in granting a waiver under this Section.

(c-5) If a long-term care facility fails to file its assessment bill with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due. After July 1, 2013, no penalty shall be assessed under this Section if the Illinois Department does not provide a process for the electronic submission of the information required by subsection (a-5).

(d) Nothing in this amendatory Act of 1993 shall be construed to prevent the Illinois Department from collecting all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

(e) Nothing in this amendatory Act of the 96th General Assembly shall be construed to prevent the Illinois Department

from collecting all amounts due under this Code pursuant to an assessment, tax, fee, or penalty imposed before the effective date of this amendatory Act of the 96th General Assembly.

(f) No installment of the assessment imposed by Section 5B-2 shall 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 5-5.2 ~~5-5.4~~ of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.2 ~~5-5.4~~ of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.2 ~~5-5.4~~ of this Code.

(Source: P.A. 100-501, eff. 6-1-18; 101-649, eff. 7-7-20.)

(305 ILCS 5/5B-5) (from Ch. 23, par. 5B-5)

Sec. 5B-5. Annual reporting; penalty; maintenance of records.

(a) 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 this Article shall file a report with the Illinois Department. The report shall be in a form and manner prescribed by the Illinois Department and shall state the revenue received by the long-term care provider, reported in such categories as may be required by the Illinois Department, and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code.

(b) If a long-term care provider operates or maintains more than one long-term care facility in this State, the provider may not file a single return covering all those long-term care facilities, but shall file a separate return for each long-term care facility and shall compute and pay the assessment for each long-term care facility separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to operate or maintain a long-term care facility in respect of which the person is subject to assessment under this Article as a long-term care provider, the person shall file a final, amended return with the Illinois Department not more than 90 days after the cessation reflecting the adjustment and shall pay with the final return the assessment for the year as so adjusted (to the extent not previously paid). If a person fails to file a final amended return on a timely basis, there shall, unless waived

by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(d) Notwithstanding any other provision of this Article, a provider who commences operating or maintaining a long-term care facility that was under a prior ownership and remained licensed by the Department of Public Health shall notify the Illinois Department of any ~~the~~ change in ownership regardless of percentage, and shall be responsible to immediately pay any prior amounts owed by the facility. In addition, beginning January 1, 2023, all providers operating or maintaining a long-term care facility shall notify the Illinois 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 requirement.

(e) The Department shall develop a procedure for sharing with a potential buyer of a facility information regarding outstanding assessments and penalties owed by that facility.

(f) In the case of a long-term care provider existing as a corporation or legal entity other than an individual, the return filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly

authorized agent.

(g) If a long-term care provider fails to file its return on or before the due date of the return, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty assessment equal to 25% of the assessment imposed for the year. After July 1, 2013, no penalty shall be assessed if the Illinois Department has not established a process for the electronic submission of information.

(h) Every long-term care provider subject to assessment under this Article shall keep records and books that will permit the determination of occupied bed days on a calendar year basis. All such books and records shall be kept in the English language and shall, at all times during business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(i) The Illinois Department shall establish a process for long-term care providers to electronically submit all information required by this Section no later than July 1, 2013.

(Source: P.A. 96-1530, eff. 2-16-11; 97-403, eff. 1-1-12; 97-813, eff. 7-13-12.)

(305 ILCS 5/5B-8) (from Ch. 23, par. 5B-8)

Sec. 5B-8. Long-Term Care Provider Fund.

(a) There is created in the State Treasury the Long-Term

Care Provider Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Article. Disbursements from the Fund shall be made only as follows:

(1) For payments to nursing facilities, including county nursing facilities but excluding State-operated facilities, under Title XIX of the Social Security Act and Article V of this Code.

(1.5) For payments to managed care organizations as defined in Section 5-30.1 of this Code.

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing the activities authorized by this Article.

(3.5) For reimbursement of expenses incurred by long-term care facilities, and payment of administrative expenses incurred by the Department of Public Health, in relation to the conduct and analysis of background checks for identified offenders under the Nursing Home Care Act.

(4) For payments of any amounts that are reimbursable to the federal government for payments from this Fund that are required to be paid by State warrant.

(5) For making transfers to the General Obligation Bond Retirement and Interest Fund, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers, at the direction of the Director of the Governor's Office of Management and Budget during each fiscal year beginning on or after July 1, 2011, to other State funds in an annual amount of $20,000,000 of the tax collected pursuant to this Article for the purpose of enforcement of nursing home standards, support of the ombudsman program, and efforts to expand home and community-based services. No transfer under this paragraph shall occur until (i) the payment methodologies created by Public Act 96-1530 under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Disbursements from the Fund, other than transfers made pursuant to paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois

Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the long-term care provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made from the Fund ~~by the Illinois Department that are attributable to moneys deposited in the Fund~~.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) (Blank).

(5) All other monies received for the Fund from any other source, including interest earned thereon.

(Source: P.A. 96-1530, eff. 2-16-11; 97-584, eff. 8-26-11.)

(305 ILCS 5/5E-10)

Sec. 5E-10. Fee. Through June 30, 2022 or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1) of Section 5B-2 of this Code, whichever is later, every ~~Every~~ nursing home provider shall pay to the Illinois Department, on or before September 10, December 10, March 10, and June 10, a fee in the amount of $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. This fee shall not be billed or passed on to any

resident of a nursing home operated by the nursing home provider. All fees received by the Illinois Department under this Section shall be deposited into the Long-Term Care Provider Fund.

(Source: P.A. 88-88; 89-21, eff. 7-1-95.)

(305 ILCS 5/5E-20 new)

Sec. 5E-20. Repealer. This Article 5E is repealed on July 1, 2024.

Section 99. Effective date. This Act takes effect upon becoming law.