



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

SB1840

Introduced 2/26/2021, by Sen. Mattie Hunter

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Community Benefits Act. Provides that the Act applies to all nonprofit and public hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act (rather than not applying to a hospital operated by a unit of government, a hospital located outside of a metropolitan statistical area, or a hospital with 100 or fewer beds). Requires community benefits plans to describe activities the hospital is undertaking to address health equity, reduce health disparities, and improve community health. Provides that, in order to increase transparency and accessibility of charity care and financial assistance data, the Attorney General shall post on the Attorney General's website: all community benefits plans contained in reports submitted by hospitals; and a compiled report that summarizes information from completed community benefits plans. Provides that an electronic version of the compiled report shall be sent to the Governor and each member of the General Assembly. Provides a late filing fee for nonprofit hospitals for community benefits plans of \$2,500 per month that the report is late (rather than \$100). Makes other changes. Amends the Hospital Uninsured Patient Discount Act. Provides that hospitals, other than a rural hospital or Critical Access Hospitals, shall provide a discount from charges to specified uninsured patients for all medically necessary health care services exceeding \$150 (rather than \$300) in any one inpatient admission or outpatient encounter. Provides civil monetary penalties of not \$1,000 to \$5,000 (rather than \$500). Requires the Attorney General to publish an annual report that outlines complaints received related to hospital uninsured discount programs and financial assistance applications. Makes other changes. Effective immediately.

LRB102 15013 CPF 20368 b

1 AN ACT concerning regulation.

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

4 Section 5. The Community Benefits Act is amended by  
5 changing Sections 5, 10, 15, 20, and 25 and by adding Section  
6 22 as follows:

7 (210 ILCS 76/5)

8 Sec. 5. Applicability. This Act applies to all nonprofit  
9 and public hospitals licensed under the Hospital Licensing Act  
10 or operated under the University of Illinois Hospital Act.  
11 ~~This Act does not apply to a hospital operated by a unit of~~  
12 ~~government, a hospital located outside of a metropolitan~~  
13 ~~statistical area, or a hospital with 100 or fewer beds.~~  
14 Hospitals that are owned or operated by or affiliated with a  
15 health system shall be deemed to be in compliance with this Act  
16 if the health system has met the requirements of this Act.

17 (Source: P.A. 93-480, eff. 8-8-03.)

18 (210 ILCS 76/10)

19 Sec. 10. Definitions. As used in this Act:

20 "Bad debt" means any bill submitted to a patient or  
21 guarantor where efforts to collect are exhausted and the bill  
22 is not paid in full.

1 "Charity care" means care provided by a health care  
2 provider for which the provider does not expect to receive  
3 payment from the patient or a third party payer. "Charity  
4 care" includes the actual cost of services provided based upon  
5 the total cost to charge ratio derived from the nonprofit  
6 hospital's Medicare cost report and not based upon the charges  
7 for the services. "Charity care" does not include bad debt.

8 "Community benefits" means the unreimbursed cost to a  
9 hospital or health system of providing charity care, language  
10 assistant services, government-sponsored ~~indigent~~ health care,  
11 donations, volunteer services, education,  
12 government-sponsored program services, research, and  
13 subsidized health services and collecting bad debts.  
14 "Community benefits" does not include the cost of paying any  
15 taxes or other governmental assessments.

16 "Cost to charge ratio" means the ratio between a  
17 hospital's expenses and what the hospital charges, and service  
18 costs relative to the charges assigned by the hospital, as  
19 provided in the hospital's Medicare Cost Report.

20 "Financial assistance" means care given at a reduced rate  
21 or no cost due to the inability of the patient to pay for such  
22 care as a result of being uninsured or underinsured under the  
23 terms and conditions the hospital offers to qualified patients  
24 and as required by law.

25 "~~Government-sponsored~~Government sponsored indigent health  
26 care" means the unreimbursed cost to a hospital or health

1 system of Medicare, providing health care services to  
2 recipients of Medicaid, and other federal, State, or local  
3 ~~indigent~~ health care programs, eligibility for which is based  
4 on financial need.

5 "Health system" means an entity that owns or operates at  
6 least one hospital.

7 "Net patient revenue" means the amount a hospital or  
8 health system expects to be received from a public or private  
9 health insurance payer, or paid directly in the form of  
10 copayments, coinsurance, or other payment, for health care  
11 services provided by the hospital or health system.

12 "Nonprofit hospital" means a hospital that is organized as  
13 a nonprofit corporation, including religious organizations, or  
14 a charitable trust under Illinois law or the laws of any other  
15 state or country.

16 "Subsidized health services" means those services provided  
17 by a hospital in response to community needs for which the  
18 reimbursement is less than the hospital's cost of providing  
19 the services that must be subsidized by other hospital or  
20 nonprofit supporting entity revenue sources. "Subsidized  
21 health services" includes, but is not limited to, emergency  
22 and trauma care, neonatal intensive care, community health  
23 clinics, and collaborative efforts with local government or  
24 private agencies to prevent illness and improve wellness, such  
25 as immunization programs.

26 (Source: P.A. 93-480, eff. 8-8-03.)

1 (210 ILCS 76/15)

2 Sec. 15. Organizational mission statement; community  
3 benefits plan. A nonprofit hospital shall develop:

4 (1) an organizational mission statement that  
5 identifies the hospital's commitment to serving the health  
6 care needs of the community; and

7 (2) a community benefits plan defined as an  
8 operational plan for serving the community's health care  
9 needs that:

10 (A) sets out goals and objectives for providing  
11 community benefits that include charity care and  
12 government-sponsored ~~government-sponsored indigent~~  
13 health care; ~~and~~

14 (B) identifies the populations and communities  
15 served by the hospital; ~~and~~

16 (C) describes activities the hospital is  
17 undertaking to address health equity, reduce health  
18 disparities, and improve community health. This may  
19 include, but is not limited to:

20 (i) efforts to recruit and promote a racially  
21 and culturally diverse and representative  
22 workforce;

23 (ii) efforts to procure goods and services  
24 locally and from historically underrepresented  
25 communities;

- 1                   (iii) training that addresses cultural  
2                   competency and implicit bias; and  
3                   (iv) partnerships and investments to address  
4                   social needs such as food, housing, and community  
5                   safety.

6           (Source: P.A. 93-480, eff. 8-8-03.)

7           (210 ILCS 76/20)

8           Sec. 20. Annual report for community benefits plan.

9           (a) Each nonprofit hospital shall prepare an annual report  
10          of the community benefits plan. The report must include, in  
11          addition to the community benefits plan itself, all of the  
12          following background information:

13               (1) The hospital's mission statement.

14               (2) A disclosure of the health care needs of the  
15          community that were considered in developing the  
16          hospital's community benefits plan.

17               (3) A disclosure of the amount and types of community  
18          benefits actually provided, including charity care, and  
19          details about financial assistance applications received  
20          and processed by hospitals as specified in paragraph (5)  
21          of subsection (a) of Section 22. Charity care must be  
22          reported separate from other community benefits. In  
23          reporting charity care, the hospital must report the  
24          actual cost of services provided, based on the total cost  
25          to charge ratio derived from the hospital's Medicare cost

1 report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient  
2 Ratios), not the charges for the services. For a health  
3 system that includes more than one hospital, charity care  
4 spending and financial assistance application data must be  
5 reported separately for each individual hospital within  
6 the health system.

7 (4) Audited annual financial reports for its most  
8 recently completed fiscal year.

9 (b) Each nonprofit hospital shall annually file a report  
10 of the community benefits plan with the Attorney General. The  
11 report must be filed not later than the last day of the sixth  
12 month after the close of the hospital's fiscal year, beginning  
13 with the hospital fiscal year that ends in 2004.

14 (c) Each nonprofit hospital shall prepare a statement that  
15 notifies the public that the annual report of the community  
16 benefits plan is:

17 (1) public information;

18 (2) filed with the Attorney General; and

19 (3) available to the public on request from the  
20 Attorney General.

21 This statement shall be made available to the public.

22 (d) The obligations of a hospital under this Act, except  
23 for the filing of its audited financial report, shall take  
24 effect beginning with the hospital's fiscal year that begins  
25 after the effective date of this Act. Within 60 days of the  
26 effective date of this Act, a hospital shall file the audited

1 annual financial report that has been completed for its most  
2 recently completed fiscal year. Thereafter, a hospital shall  
3 include its audited annual financial report for its most  
4 recently completed fiscal year in its annual report of its  
5 community benefits plan.

6 (Source: P.A. 93-480, eff. 8-8-03.)

7 (210 ILCS 76/22 new)

8 Sec. 22. Public reports.

9 (a) In order to increase transparency and accessibility of  
10 charity care and financial assistance data, the Attorney  
11 General shall post on the Attorney General's website: all  
12 community benefits plans contained in reports submitted by  
13 hospitals under Section 20; and a compiled report that  
14 summarizes information from completed community benefits  
15 plans. Past reports and disclosures shall remain publicly  
16 available on the website for at least 15 years. Numerical data  
17 shall be published in XML, CSV, and PDF file formats.  
18 Hospitals shall also make this information available to the  
19 public by publishing this information on the hospital's  
20 website in the same location where annual reports are posted.  
21 Information made available to the public shall include, but  
22 not be limited to, the following:

23 (1) The reporting period.

24 (2) Charity care costs consistent with the reporting  
25 requirements in paragraph (3) of subsection (a) of Section



1       20. Charity care costs associated with services provided  
2       as part of a hospital's obligation to comply with the  
3       federal Emergency Medical Treatment and Labor Act shall be  
4       reported as a subset of total charity care costs.

5           (3) Total net patient revenue, reported separately by  
6       hospital if the reporting health system includes more than  
7       one hospital.

8           (4) Total community benefits spending.

9           (5) Data on financial assistance applications  
10       consistent with the reporting requirements in paragraph  
11       (3) of subsection (a) Section 20, including:

12           (A) the number of applications submitted to the  
13       hospital, both complete and incomplete;

14           (B) the number of applications approved, with  
15       details as to whether the approval was for full or  
16       partial financial assistance, as well as the type of  
17       service, including inpatient, outpatient, emergency  
18       department, or other, associated with the approved  
19       application; and

20           (C) the number of applications denied, the 5 most  
21       frequent reasons for denial, and the type of services  
22       associated with the denied application, including  
23       inpatient, outpatient, emergency department, or other.

24           (6) To the extent that race, ethnicity, or preferred  
25       language is collected and available for financial  
26       assistance applications, the data outlined in paragraph

1       (5) shall be reported by race, ethnicity, gender,  
2       employment status, occupation, housing status, and primary  
3       language. If this data is not provided by the patient, the  
4       hospital shall indicate this in its reports.

5       (b) An electronic version of the Attorney General report  
6       under subsection (a) shall be sent to the Governor and each  
7       member of the General Assembly.

8           (210 ILCS 76/25)

9       Sec. 25. Failure to file annual report. The Attorney  
10      General may assess a late filing fee against a nonprofit  
11      hospital that fails to make a report of the community benefits  
12      plan as required under this Act in an amount not to exceed  
13      \$2,500 per month that the report is late ~~\$100~~. The Attorney  
14      General may grant extensions for good cause. No penalty may be  
15      assessed against a hospital under this Section until 30  
16      business days have elapsed after written notification to the  
17      hospital of its failure to file a report.

18      (Source: P.A. 93-480, eff. 8-8-03.)

19           Section 10. The Hospital Uninsured Patient Discount Act is  
20      amended by changing Sections 5, 10, 15, and 25 as follows:

21           (210 ILCS 89/5)

22      Sec. 5. Definitions. As used in this Act:

23      "Cost to charge ratio" means the ratio of a hospital's

1 costs to its charges taken from its most recently filed  
2 Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS  
3 Inpatient Ratios).

4 "Critical Access Hospital" means a hospital that is  
5 designated as such under the federal Medicare Rural Hospital  
6 Flexibility Program.

7 "Family income" means the sum of a family's annual  
8 earnings and cash benefits from all sources before taxes, less  
9 payments made for child support.

10 "Federal poverty income guidelines" means the poverty  
11 guidelines updated periodically in the Federal Register by the  
12 United States Department of Health and Human Services under  
13 authority of 42 U.S.C. 9902(2).

14 "Financial assistance" means care given at a reduced rate  
15 or no cost due to the inability of the patient to pay for such  
16 care as a result of being uninsured or underinsured under the  
17 terms and conditions the hospital offers to qualified patients  
18 and as required by law.

19 "Health care services" means any medically necessary  
20 inpatient or outpatient hospital service, including  
21 pharmaceuticals or supplies provided by a hospital to a  
22 patient.

23 "Hospital" means any facility or institution required to  
24 be licensed pursuant to the Hospital Licensing Act or operated  
25 under the University of Illinois Hospital Act.

26 "Illinois resident" means any a person who lives in

1 Illinois and who intends to remain living in Illinois  
2 indefinitely. Relocation to Illinois for the sole purpose of  
3 receiving health care benefits does not satisfy the residency  
4 requirement under this Act.

5 "Medically necessary" means any inpatient or outpatient  
6 hospital service, including pharmaceuticals or supplies  
7 provided by a hospital to a patient, covered under Title XVIII  
8 of the federal Social Security Act for beneficiaries with the  
9 same clinical presentation as the uninsured patient. A  
10 "medically necessary" service does not include any of the  
11 following:

12 (1) Non-medical services such as social and vocational  
13 services.

14 (2) Elective cosmetic surgery, but not plastic surgery  
15 designed to correct disfigurement caused by injury,  
16 illness, or congenital defect or deformity.

17 "Rural hospital" means a hospital that is located outside  
18 a metropolitan statistical area.

19 "Uninsured discount" means a hospital's charges multiplied  
20 by the uninsured discount factor.

21 "Uninsured discount factor" means 1.0 less the product of  
22 a hospital's cost to charge ratio multiplied by 1.35.

23 "Uninsured patient" means an Illinois resident who ~~is a~~  
24 ~~patient of a hospital and~~ is not covered under a policy of  
25 health insurance and is not a beneficiary under a public or  
26 private health insurance, health benefit, or other health

1 coverage program, including high deductible health insurance  
2 plans, workers' compensation, accident liability insurance, or  
3 other third party liability.

4 (Source: P.A. 95-965, eff. 12-22-08.)

5 (210 ILCS 89/10)

6 Sec. 10. Uninsured patient discounts.

7 (a) Eligibility.

8 (1) A hospital, other than a rural hospital or  
9 Critical Access Hospital, shall provide a discount from  
10 its charges to any uninsured patient who applies for a  
11 discount and has family income of not more than 600% of the  
12 federal poverty income guidelines for all medically  
13 necessary health care services exceeding \$150 ~~\$300~~ in any  
14 one inpatient admission or outpatient encounter.

15 (2) A hospital, other than a rural hospital or  
16 Critical Access Hospital, shall provide a charitable  
17 discount of 100% of its charges for all medically  
18 necessary health care services exceeding \$150 ~~\$300~~ in any  
19 one inpatient admission or outpatient encounter to any  
20 uninsured patient who applies for a discount and has  
21 family income of not more than 200% of the federal poverty  
22 income guidelines.

23 (3) A rural hospital or Critical Access Hospital shall  
24 provide a discount from its charges to any uninsured  
25 patient who applies for a discount and has annual family

1 income of not more than 300% of the federal poverty income  
2 guidelines for all medically necessary health care  
3 services exceeding \$300 in any one inpatient admission or  
4 outpatient encounter.

5 Hospitals shall notify patients of their ability to  
6 include health care received in the last 12 months towards  
7 the maximum collectable amount. This information shall be  
8 included clearly and in plain language on financial  
9 assistance applications, hospital bills, invoices, or  
10 summary of charges provided by the hospital.

11 (4) A rural hospital or Critical Access Hospital shall  
12 provide a charitable discount of 100% of its charges for  
13 all medically necessary health care services exceeding  
14 \$300 in any one inpatient admission or outpatient  
15 encounter to any uninsured patient who applies for a  
16 discount and has family income of not more than 125% of the  
17 federal poverty income guidelines.

18 (b) Discount. For all health care services exceeding \$300  
19 in any one inpatient admission or outpatient encounter, a  
20 hospital shall not collect from an uninsured patient, deemed  
21 eligible under subsection (a), more than its charges less the  
22 amount of the uninsured discount.

23 (c) Maximum Collectible Amount.

24 (1) The maximum amount that may be collected in a 12  
25 month period for health care services provided by the  
26 hospital from a patient determined by that hospital to be

1 eligible under subsection (a) is 15% ~~25%~~ of the patient's  
2 family income, and is subject to the patient's continued  
3 eligibility under this Act.

4 (2) The 12 month period to which the maximum amount  
5 applies shall begin on the first date, after the effective  
6 date of this Act, an uninsured patient receives health  
7 care services that are determined to be eligible for the  
8 uninsured discount at that hospital.

9 (3) To be eligible to have this maximum amount applied  
10 to subsequent charges, the uninsured patient shall inform  
11 the hospital in subsequent inpatient admissions or  
12 outpatient encounters that the patient has previously  
13 received health care services from that hospital and was  
14 determined to be entitled to the uninsured discount.

15 (4) Hospitals may adopt policies to exclude an  
16 uninsured patient from the application of subdivision  
17 (c)(1) when the patient owns assets having a value in  
18 excess of 600% of the federal poverty level for hospitals  
19 in a metropolitan statistical area or owns assets having a  
20 value in excess of 300% of the federal poverty level for  
21 Critical Access Hospitals or hospitals outside a  
22 metropolitan statistical area, not counting the following  
23 assets: the uninsured patient's primary residence;  
24 personal property exempt from judgment under Section  
25 12-1001 of the Code of Civil Procedure; or any amounts  
26 held in a pension or retirement plan, provided, however,

1           that distributions and payments from pension or retirement  
2           plans may be included as income for the purposes of this  
3           Act.

4           (d) Each hospital bill, invoice, or other summary of  
5           charges to an uninsured patient shall include with it, or on  
6           it, a prominent statement that an uninsured patient who meets  
7           certain income requirements may qualify for an uninsured  
8           discount and information regarding how an uninsured patient  
9           may apply for consideration under the hospital's financial  
10          assistance policy. Each hospital bill, invoice, or other  
11          summary of charges to an uninsured patient shall state:  
12          "Complaints or concerns with the uninsured patient discount  
13          application process or hospital financial assistance process  
14          may be reported to the Health Care Bureau of the Illinois  
15          Attorney General." A website, phone number, or both provided  
16          by the Attorney General shall be included with this statement.  
17          (Source: P.A. 97-690, eff. 6-14-12.)

18           (210 ILCS 89/15)

19           Sec. 15. Patient responsibility.

20           (a) Hospitals may make the availability of a discount and  
21           the maximum collectible amount under this Act contingent upon  
22           the uninsured patient first applying for coverage under public  
23           programs, such as Medicare, Medicaid, AllKids, the State  
24           Children's Health Insurance Program, or any other program, if  
25           there is a reasonable basis to believe that the uninsured



1 patient may be eligible for such program.

2 (b) Hospitals shall permit an uninsured patient to  
3 initiate an application for financial assistance prior to the  
4 receipt of a service ~~apply for a discount~~ within 60 days of the  
5 date of discharge or date of service. Hospitals shall permit  
6 uninsured patients with an inpatient hospital stay of 20 or  
7 more days to initiate an application for financial assistance  
8 within 90 days after the date of discharge.

9 (1) Income verification. Hospitals may require an  
10 uninsured patient who is requesting an uninsured discount  
11 to provide documentation of family income. Acceptable  
12 family income documentation shall include any one of the  
13 following:

14 (A) a copy of the most recent tax return;

15 (B) a copy of the most recent W-2 form and 1099  
16 forms;

17 (C) copies of the 2 most recent pay stubs;

18 (D) written income verification from an employer  
19 if paid in cash; or

20 (E) one other reasonable form of third party  
21 income verification deemed acceptable to the hospital.

22 (2) Asset verification. Hospitals may require an  
23 uninsured patient who is requesting an uninsured discount  
24 to certify the existence or absence of assets owned by the  
25 patient and to provide documentation of the value of such  
26 assets, except for those assets referenced in paragraph

1       (5) of subsection (c) of Section 10. Acceptable  
2 documentation may include statements from financial  
3 institutions or some other third party verification of an  
4 asset's value. If no third party verification exists, then  
5 the patient shall certify as to the estimated value of the  
6 asset.

7       (3) Illinois resident verification. Hospitals may  
8 require an uninsured patient who is requesting an  
9 uninsured discount to verify Illinois residency.  
10 Acceptable verification of Illinois residency shall  
11 include any one of the following:

12               (A) any of the documents listed in paragraph (1);

13               (B) a valid state-issued identification card;

14               (C) a recent residential utility bill;

15               (D) a lease agreement;

16               (E) a vehicle registration card;

17               (F) a voter registration card;

18               (G) mail addressed to the uninsured patient at an  
19 Illinois address from a government or other credible  
20 source;

21               (H) a statement from a family member of the  
22 uninsured patient who resides at the same address and  
23 presents verification of residency; ~~or~~

24               (I) a letter from a homeless shelter, transitional  
25 house or other similar facility verifying that the  
26 uninsured patient resides at the facility; or.

1                   (J) a temporary visitor's drivers license.

2           (c) Hospital obligations toward an individual uninsured  
3 patient under this Act shall cease if that patient  
4 unreasonably fails or refuses to provide the hospital with  
5 information or documentation requested under subsection (b) or  
6 to apply for coverage under public programs when requested  
7 under subsection (a) within 30 days of the hospital's request.

8           (d) In order for a hospital to determine the 12 month  
9 maximum amount that can be collected from a patient deemed  
10 eligible under Section 10, an uninsured patient shall inform  
11 the hospital in subsequent inpatient admissions or outpatient  
12 encounters that the patient has previously received health  
13 care services from that hospital and was determined to be  
14 entitled to the uninsured discount.

15           (e) Hospitals may require patients to certify that all of  
16 the information provided in the application is true. The  
17 application may state that if any of the information is  
18 untrue, any discount granted to the patient is forfeited and  
19 the patient is responsible for payment of the hospital's full  
20 charges.

21           (f) Hospitals shall ask for an applicant's race,  
22 ethnicity, gender, employment status, occupation, housing  
23 status, and preferred language on the financial assistance  
24 application. However, the questions shall be clearly marked as  
25 optional responses for the patient and shall note that  
26 responses or nonresponses by the patient will not have any

1 impact on the outcome of the application.

2 (Source: P.A. 95-965, eff. 12-22-08.)

3 (210 ILCS 89/25)

4 Sec. 25. Enforcement.

5 (a) The Attorney General is responsible for administering  
6 and ensuring compliance with this Act, including the  
7 development of any rules necessary for the implementation and  
8 enforcement of this Act.

9 (b) The Attorney General shall develop and implement a  
10 process for receiving and handling complaints from individuals  
11 or hospitals regarding possible violations of this Act.

12 (c) The Attorney General may conduct any investigation  
13 deemed necessary regarding possible violations of this Act by  
14 any hospital including, without limitation, the issuance of  
15 subpoenas to:

16 (1) require the hospital to file a statement or report  
17 or answer interrogatories in writing as to all information  
18 relevant to the alleged violations;

19 (2) examine under oath any person who possesses  
20 knowledge or information directly related to the alleged  
21 violations; and

22 (3) examine any record, book, document, account, or  
23 paper necessary to investigate the alleged violation.

24 (d) If the Attorney General determines that there is a  
25 reason to believe that any hospital has violated this Act, the

1 Attorney General may bring an action in the name of the People  
2 of the State against the hospital to obtain temporary,  
3 preliminary, or permanent injunctive relief for any act,  
4 policy, or practice by the hospital that violates this Act.  
5 Before bringing such an action, the Attorney General may  
6 permit the hospital to submit a Correction Plan for the  
7 Attorney General's approval.

8 (e) This Section applies if:

9 (1) A court orders a party to make payments to the  
10 Attorney General and the payments are to be used for the  
11 operations of the Office of the Attorney General; or

12 (2) A party agrees in a Correction Plan under this Act  
13 to make payments to the Attorney General for the  
14 operations of the Office of the Attorney General.

15 (f) Moneys paid under any of the conditions described in  
16 subsection (e) shall be deposited into the Attorney General  
17 Court Ordered and Voluntary Compliance Payment Projects Fund.  
18 Moneys in the Fund shall be used, subject to appropriation,  
19 for the performance of any function, pertaining to the  
20 exercise of the duties, to the Attorney General including, but  
21 not limited to, enforcement of any law of this State and  
22 conducting public education programs; however, any moneys in  
23 the Fund that are required by the court to be used for a  
24 particular purpose shall be used for that purpose.

25 (g) The Attorney General may seek the assessment of a  
26 civil monetary penalty of not less than \$1,000 but not to

1 exceed \$5,000 for a ~~\$500 per~~ violation in any action filed  
2 under this Act where a hospital, by pattern or practice,  
3 knowingly violates Section 10 of this Act.

4 (h) In the event a court grants a final order of relief  
5 against any hospital for a violation of this Act, the Attorney  
6 General may, after all appeal rights have been exhausted,  
7 refer the hospital to the Illinois Department of Public Health  
8 for possible adverse licensure action under the Hospital  
9 Licensing Act.

10 (i) Each hospital shall file Worksheet C Part I from its  
11 most recently filed Medicare Cost Report with the Attorney  
12 General within 60 days after the effective date of this Act and  
13 thereafter shall file each subsequent Worksheet C Part I with  
14 the Attorney General within 30 days of filing its Medicare  
15 Cost Report with the hospital's fiscal intermediary.

16 (j) On and after January 1, 2022, the Attorney General  
17 shall publish an annual report that outlines complaints  
18 received related to hospital uninsured discount programs and  
19 financial assistance applications. The initial report shall  
20 include the following:

21 (1) The number of complaints received, listed by  
22 hospital.

23 (2) The status of each of the complaints.

24 (3) The number of violations found by the Attorney  
25 General, and any actions, including monetary penalties  
26 issued by the Attorney General, since January 1, 2012.

1       Numerical data shall be published in XML, CSV, and PDF  
2       file formats. Subsequent annual reports may be limited to  
3       only reflect the most recent completed calendar year.

4       (Source: P.A. 95-965, eff. 12-22-08.)

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

1 INDEX

2 Statutes amended in order of appearance

- 3 210 ILCS 76/5
- 4 210 ILCS 76/10
- 5 210 ILCS 76/15
- 6 210 ILCS 76/20
- 7 210 ILCS 76/22 new
- 8 210 ILCS 76/25
- 9 210 ILCS 89/5
- 10 210 ILCS 89/10
- 11 210 ILCS 89/15
- 12 210 ILCS 89/25