AN ACT concerning aging.

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

Section 1. Short title. This Act may be cited as the Comprehensive Housing, Health, and Supportive Services for Older Adults Act.

Section 5. Purpose. The purpose of this Act is to permit the development and availability of a comprehensive, affordable, and sustainable system of housing, health, and supportive services for older residents of Illinois. A basic set of services should be available in all areas of the State. Services must be of the highest quality, client-focused, consumer-directed, and cost-effective. These services shall be designed to meet the individual and his or her family's changing needs and preferences and to encourage family and community involvement. The services available are intended to assist individuals to remain as independent as possible, regardless of their residential setting.

Section 10. Definitions. In this Act:

"Caregiver" means the family member or other natural person who normally provides the daily care or supervision of an older adult.

"Comprehensive case management" means services and activities that will assist eligible persons to gain access to housing, health, and supportive services, regardless of the residential setting in which provided.

"Coordinating Committee" means the Housing, Health, and Supportive Services for Older Adults Coordinating Committee.

"Critical access area" means an area of the State that is identified by the directors of Public Health and Aging as being underserved in the areas of housing, health, and supportive

services on the basis of being more than 30 minutes in travel time, under normal driving conditions, from the next nearest provider or being the sole provider located in an underserved area or health professional shortage area.

"Critical access plan" means the plan developed pursuant to Section 15 of this Act.

"Critical access provider" means a provider located in a critical access area.

"Eligible nursing home" means any nursing home licensed under the Nursing Home Care Act and certified under Title XVIII of the Social Security Act to participate as a vendor in the medical assistance program under Article V of the Illinois Public Aid Code.

"Health services" means activities that promote, maintain, improve, or restore mental or physical health.

"Long-term care services" means the range of services, other than acute care services that provide time-limited curative or restorative treatment, that are delivered to an older adult with functional or cognitive limitations who requires assistance to perform activities of daily living, regardless of the residential setting in which the services are delivered, by a nurse, health aide, or personal attendant.

"Older adult" means a person age 60 or older.

"Provider" means any supplier of services to an older adult under this Act.

"Residential setting" means the place where an older adult lives, independent of ownership, including but not limited to the older adult's own residence, respite care, a nursing home, senior housing, a supportive living facility, an assisted living or shared housing establishment, or a community-based residential alternative.

"Respite care" means the provision of intermittent and temporary substitute care or supervision to an older adult on behalf of and in the absence of the primary caregiver, for the purpose of providing relief from the responsibilities of providing constant care, so as to enable the caregiver to

continue to provide care in the older adult's home. The term includes care provided in the older adult's home, in adult day care, in a senior center during the day or overnight, or in another residential setting.

"Senior center" means a community senior services and resource center as described in the Community Senior Services and Resources Act to conserve community resources by providing older adults with access to services most appropriate to the individual. The term includes a non-profit organization or unit of local government located in a permanent facility that offers 5 or more programs that meet the needs of older adults and their families, 7 hours per day, 5 days per week.

"Services" includes housing, health, and supportive services.

"Supportive services" includes the following: adult day services; caregiver support; case management; computer literacy; congregate meals; counseling; elder abuse prevention and intervention; emergency response systems; home-delivered meals; in-home services; job training and placement; medication reminder systems; monitoring systems; ombudsman services; respite care; senior benefits outreach; telemedicine; transportation; wellness and fitness programs; senior center services; and any other program that maximizes participants' health, safety, and well-being, regardless of residential setting.

"Telemedicine" means the use of telecommunications technology by a provider to deliver health services at a site other than the site where the provider is located.

Section 15. Distribution of housing and services.

(a) The Director of Aging, in collaboration with the directors of Public Health and Public Aid and in consultation with the Coordinating Committee, shall monitor and analyze the distribution of services for older adults in each geographic area of the State. The Director of Aging shall submit to the legislature, no later than July 1, 2005, and every 5 years

thereafter, an assessment of the impact of the distribution of housing and services by geographic area, with particular attention to service deficits or problems, designating critical access service areas and a corrective action plan.

(b) The directors of Public Health, Aging, and Public Aid, in consultation with the Coordinating Committee, shall identify and designate specific geographic areas as critical access service areas.

(c) No later than July 1, 2005, for programs under their respective jurisdiction, the directors of Public Health, Aging, and Public Aid, in consultation with the Coordinating Committee, shall implement the initial stages of a plan to do the following:

(1) develop and implement specific waivers of regulations governing services to address service needs for older adults in critical access service areas;

(2) give priority to the distribution of funds for new, expansion, or transition services to critical access service areas; and

(3) identify funding barriers and provide recommendations on changes to reimbursement methodologies to facilitate the continued operation of these services in critical access service areas.

Section 20. Barriers to long-term care services. The directors of Aging, Public Aid, and Public Health, in consultation with the Coordinating Committee, shall identify barriers to the provision of long-term care services and shall implement a plan to address these barriers no later than July 1, 2005. Areas to be examined shall include, but are not limited to, regulatory complexity, State requirements, federal requirements and reimbursement, payment, and labor force issues. The plan may include, but is not limited to, changes to State or federal laws or rules or regulations, or application for federal waivers.

Section 25. Nursing home conversion program.

(a) The Illinois Finance Authority shall administer the nursing home conversion program. The Nursing Home Conversion Fund is created for this purpose. Beginning June 30, 2004, on June 30 of each State fiscal year the State Comptroller shall direct and the State Treasurer shall transfer an amount equal to 25% of the unexpended and unreserved balance in the Long Term Care Monitor/Receiver Fund to the Nursing Home Conversion Fund. Amounts transferred to the Nursing Home Conversion Fund under this subsection shall carry over into subsequent fiscal years and shall not revert to the General Revenue Fund and is not subject to Section 8h of the State Finance Act.

(b) The Illinois Finance Authority shall establish an application process for the conversion program. The Authority, in collaboration with the Department on Aging and the departments of Public Health and Public Aid, shall make grants available to nursing homes from the Nursing Home Conversion Fund for capital and other costs related to (i) the conversion of all or part of a nursing home to an assisted living establishment licensed under the Assisted Living and Shared Housing Act, a supportive living facility established under Section 5-5.01a of the Illinois Public Aid Code, or a special program or unit for persons with Alzheimer's disease and related disorders licensed under the Assisted Living and Shared Housing Act or (ii) the conversion of multi-resident bedrooms in the facility into single-occupancy rooms. The Authority must seek recommendations from the directors of Aging and Public Aid before making a grant under this Section.

(c) A nursing home may not use a grant under this Section to expand a current building:

(1) except for additional space required to accommodate related supportive services, such as dining rooms, kitchen and recreation areas, or other community use areas; or

(2) unless new construction of assisted living units, which would expand parameters of the existing building, is

more cost-effective than the conversion of existing space, in which case the nursing home must agree to de-license an equivalent number of existing nursing home beds.

(d) A nursing home that is currently certified as a Medicaid provider under Title XVIII of the Social Security Act is eligible to apply for a nursing home facility conversion grant under this Section.

(e) A conversion funded in whole or in part by a grant under this Section may not have the effect of:

(1) diminishing or reducing the quality of services available to nursing home residents; or

(2) forcing any nursing home resident to involuntarily accept home or community-based services instead of nursing home services; or

(3) diminishing or reducing the supply of services in any community below the level of need.

(f) The Illinois Finance Authority shall consider the following factors in determining the distribution of grants under this Section:

(1) the bed need in the area in which the nursing home is located; and

(2) the extent to which the conversion results in the reduction of licensed nursing home beds in an area with excess beds.

(g) In approving grants under this Section, the Illinois Finance Authority shall ensure that conversion projects do not increase overall medical assistance costs for long-term care services and ensure that the supply and distribution of long-term care services are not diminished in any community.

(h) A conversion funded in whole or in part by grants under this Section is exempt from the requirements of the Illinois Health Facilities Planning Act.

(i) The Illinois Finance Authority shall provide information to the Department of Public Aid to enable that Department to document and verify the savings to the Medicaid program attributable to the nursing home conversion program

annually and shall notify the General Assembly, the Department on Aging, and the Coordinating Committee of the savings no later than January 1 of the next fiscal year.

Section 30. Transition planning grants.

(a) The Department of Public Health, in collaboration with the Department of Public Aid and the Department on Aging and in consultation with the Coordinating Committee, shall establish a program of transition planning grants to assist eligible nursing homes. The Nursing Home Transition Planning Grant Fund is created for this purpose. Beginning June 30, 2004, on June 30 of each State fiscal year the State Comptroller shall direct and the State Treasurer shall transfer an amount equal to 25% of the unexpended and unreserved balance in the Long Term Care Monitor/Receiver Fund to the Nursing Home Transition Planning Grant Fund. Amounts transferred to the Nursing Home Transition Planning Grant Fund under this subsection shall carry over into subsequent fiscal years and shall not revert to the General Revenue Fund and is not subject to Section 8h of the State Finance Act.

(b) The Director of Public Health, in collaboration with the Department of Public Aid and the Department on Aging, shall award grants to nursing homes for either or both of the following purposes:

(1) To develop strategic plans that identify the appropriate institutional and non-institutional settings necessary to meet the older adult service needs of the community. At a minimum, a strategic plan must consist of:

(A) a needs assessment to determine what older adult services are needed and desired by the community;

(B) an assessment of the appropriate residential settings in which to provide needed older adult services;

(C) an assessment identifying currently available services and their settings in the community; and

(D) a transition plan to achieve the needed outcome

identified by the assessment.

(2) To implement transition projects identified in a strategic plan, including but not limited to those requiring capital expenditures.

(c) In determining which nursing homes will receive grants under this Section, the following factors shall be considered:

(1) A description of the problem, a description of the project, and the likelihood of the project meeting identified needs. The applicant should describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organizations.

(2) The extent of community support for the nursing home and this proposed project, including support by other local long-term care providers and local community and government leaders.

(3) A balanced distribution of grants among geographic regions, and among small and large nursing homes.

(4) The financial condition of the nursing home.

(d) Construction necessitated by transition projects under this Section is exempt from the requirements of the Illinois Health Facilities Planning Act.

(e) The Director of Public Health, in collaboration with the Department of Public Aid and the Department on Aging, shall evaluate the overall effectiveness of the transition planning grant program. The Director may collect, from the nursing homes receiving grants under this Section, the information necessary to evaluate the grant program. Information related to the financial condition of individual nursing homes shall be classified as nonpublic data.

(f) The Director of Public Health shall provide information to the Department of Public Aid to enable that Department to document and verify the amount of savings to the Medicaid program attributable to the transition planning grant program annually. The Department of Public Aid shall notify the General Assembly, the Department on Aging, the Department of Public Health, and the Coordinating Committee of the savings no later

than January 1 of the next fiscal year.

Section 35. Long-term care services for older adults.

(a) At the end of each State fiscal year, except for continuing appropriations subject to subsection (b) of Section 25 of the State Finance Act any unexpended and unreserved State General Revenue Fund appropriations for long-term care for older adults, including nursing facility, older adults waiver, alternative care, and home care services, shall be deposited in the Long-Term Care Services for Older Adults Fund, which is hereby created. The Fund is not subject to Section 8h of the State Finance Act. Moneys in the Long-Term Care Services for Older Adults Fund shall be used to pay for services listed in subsection (d).

(b) Any reduction in nursing home expenditures resulting from (A) the nursing home conversion program, as documented and verified pursuant to subsection (i) of Section 25, or (B) the transition planning grant program, as documented and verified pursuant to subsection (f) of Section 30, and moneys in the Long-Term Care Services for Older Adults Fund, shall be used to fund the services described in subsection (d) of this Section.

(c) Nothing in this Act prevents a nursing home from being eligible to provide any of the services listed in subsection (d).

(d)Long-term care services for older adults include all of the following:

(1) adult day services;

(2) home health services;

(3) homemaker services;

(4) personal care;

(5) case management;

(6) respite care;

(7) services provided under the Assisted Living and Shared Housing Act, or sheltered care services that meet the requirements of the Assisted Living and Shared Housing Act, or services provided under Section 5-5.01a of the

Illinois Public Aid Code (the Supportive Living Facilities Pilot Program);

(8) emergency response services;

(9) transition services;

(10) residential care services;

(11) care-related supplies and equipment;

(12) meals delivered to the home;

(13) congregate meals;

(14) money management;

(15) transportation;

(16) companion services;

(17) nutrition services;

(18) family care services;

(19) training for direct informal caregivers;

(20) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits;

(21) environmental modifications;

(22) adult day services for persons with Alzheimer's disease and related disorders;

(23) senior centers; and

(24) other programs designed to assist older Illinoisans to remain independent and receive services in the most integrated residential setting possible for that person.

Section 37. Housing, Health, and Supportive Services for Older Adults Coordinating Committee.

(a) The Governor shall appoint the Housing, Health, and Supportive Services for Older Adults Coordinating Committee.

(b) The Committee shall be comprised of the following persons:

(1) the Director of Aging, who shall serve as chair, ex officio and nonvoting;

(2) the directors of Public Aid and Public Health, who

shall serve as vice chairs, ex officio and nonvoting;

(3) one representative each of the departments of Public Aid, Public Health, Human Services, Insurance, and Commerce and Economic Opportunity, the Department on Aging, the Office of the State Ombudsman, and the Illinois Finance Authority, all nonvoting members;

(4) one member selected from the recommendations of the statewide organization representing the Area Agencies on Aging;

(5) four members selected from the recommendations of statewide provider organizations whose membership consists of nursing homes or assisted living establishments;

(6) one member selected from the recommendations of the statewide provider organization whose membership consists of home health agencies;

(7) one member selected from the recommendations of the statewide provider organization whose membership provides case coordination services;

(8) two members selected from the recommendations of statewide senior center associations;

(9) one member selected from the recommendations of statewide provider organizations whose membership provides community care homemaker services;

(10) one member selected from the recommendations of the statewide provider organization whose membership provides community care adult day services;

(11) one member selected from the recommendations of the statewide provider organization representing nutrition project directors;

(12) two members selected from the recommendations of statewide membership-based organizations that engage solely in advocacy or legal representation on behalf of the senior population;

(13) one member selected from the recommendations of organizations representing individuals with Alzheimer's disease and related dementias;

(14) two members selected from the recommendations of statewide trade or labor unions;

(15) a professional nurse selected from the recommendations of statewide professional nursing associations; and

(16) a physician specializing in gerontology selected from the recommendations of statewide organizations representing physicians;

(c) Members of the Committee appointed under paragraphs (4) through (16) of subsection (b) shall be appointed to serve for terms of 3 years except as otherwise provided in this subsection. All such members shall be appointed no later than January 1, 2005. Six of those members' initial terms shall expire in one year; six in 2 years, and seven in 3 years. A member's term does not expire until a successor is appointed by the Governor. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of that term.

(d) The Committee shall meet at the call of the Director of Aging. The affirmative vote of 10 members of the Committee shall be necessary for Committee action.

(e) Members of the Committee shall receive no compensation for their services.

Section 40. Statewide system of comprehensive case management services; quality improvement.

(a) No later than July 1, 2005, the Director of Aging, in consultation with the Coordinating Committee, shall implement and oversee a statewide system of comprehensive case management services to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need of services, regardless of the setting in which services are provided.

(b) No later than July 1, 2005, the Director of Aging, in consultation with the Coordinating Committee, shall provide

coordination of a statewide system of comprehensive case management services, regardless of the residential setting in which the services are provided. Comprehensive case management services include, but are not limited to, the development of a comprehensive care plan through:

(A) a comprehensive assessment of the person's need for case management services;

(B) the development of a written service delivery plan;

(C) implementation of the written service delivery plan, including communication between the service provider and the referral agency, which shall be reviewed annually or whenever a significant change in the client's condition warrants a review of the plan; and

(D) monitoring overall service delivery to ensure quality and effectiveness of services, including appropriate adjustments to the plan.

In no instance may a provider of comprehensive case management services provide to an older adult information that includes any unlicensed or uncertified provider of services if the provider is required to be licensed.

(c) No later than July 1, 2005, the Director of Aging, in consultation with the Coordinating Committee, shall propose a plan to implement, no later than July 1, 2006, methods to contain costs and encourage the reduction of Medicaid long-term care expenditures. The plan shall include, but shall not be limited to:

(1) Development of a uniform, audited provider cost reporting system that is used by all payment entities to establish payments.

(2) Maximization of Medicare billing.

(3) Identification of mechanisms to reduce the number of nursing home beds, including recommendations for various sources of funding for payments to nursing homes to reduce the number of licensed beds or to assist in the conversion to other uses.

(4) Elimination or modification of State nursing home

rules that do not advance the quality of patient care and are not cost effective.

(5) Development of innovative service delivery models and applications for waivers of federal nursing home regulations to improve the efficiency and reduce the cost and paperwork required to regulate the nursing home profession that do not advance the quality of patient care and are not cost effective.

(6) Initiation of State and federal regulatory changes to permit:

(i) greater cooperation among housing, health services and supportive services providers in such areas as discharge planning and staff sharing;

(ii) greater cooperation between providers, regardless of setting in which the service is provided; and

(iii) the use of vacant nursing home beds for alternative purposes such as respite care, protective services, or adult day services.

(7) Development of strategies to provide alternative financing of long-term care services by shifting the balance of the financial responsibility for payment for long-term care services from public to private sources by promoting public-private partnerships and personal responsibility for long-term care. These strategies may include, but are not limited to, waivers of federal requirements for:

(i) private insurance coverage for long-term care;

(ii) employment programs such as medical savings accounts for long-term care;

(iii) family responsibility options, including family supplementation;

(iv) changes in Medicaid eligibility requirements to increase consumers' financial responsibility for long-term care; and

(v) methods to supplement and support family and

community care giving.

(8) Design and implementation of a voucher program to permit appropriate consumers to contract or secure, direct, manage and pay for their services. The Department of Public Aid shall apply for any federal waivers required to implement this program.

(d) No later than July 1, 2005, the Director of Aging, in consultation with the Coordinating Committee, shall propose a plan to implement, no later than July 1, 2006, methods to improve quality, including but not limited to:

(1) Development and implementation of a plan to stabilize the worker pool by using resources such as grants, education, and promotion of long-term care careers.

(2) Design, development, and implementation of provider standards.

(3) Design, development, and implementation of a plan for a comprehensive Internet based resource of available services.

(e) Long-term care service models that are developed as alternatives to nursing home models must be comparable in cost or more cost-effective than the nursing home models that provide equivalent services. Any long-term care service models identified must be financially viable, must be cost-effective, must promote consumer independence, participation, and non-institutionalization and, when appropriate, consumer direction, and may include one or a combination of services such as assisted living, adult foster care, attendant care, and modifications of the residential care home system.

(f) On July 1, 2005, and annually thereafter, the Department on Aging shall report to the General Assembly regarding the progress made in complying with the requirements of this Section 40.

Section 45. Local regulation. Notwithstanding any local ordinance related to development, planning, or zoning to the

contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service.

Section 50. Quality standards.

(a) The directors of Public Health, Public Aid, and Aging, in consultation with the Coordinating Committee, shall establish a core set of uniform quality standards for all housing and services providers under this Act. The standards must focus on outcomes and take into consideration client choices and satisfaction.

(b) Each provider must implement a continuous quality improvement process to address client issues that must include the core set of uniform quality standards identified by the directors. The continuous quality improvement process must benchmark performance, be client-centered and data-driven, and focus on client satisfaction.

Section 90. The Illinois Health Facilities Planning Act is amended by changing Section 3 as follows:

(20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

(Section scheduled to be repealed on July 1, 2008)

Sec. 3. Definitions. As used in this Act:

"Health care facilities" means and includes the following facilities and organizations:

1. An ambulatory surgical treatment center required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act;

2. An institution, place, building, or agency required to be licensed pursuant to the Hospital Licensing Act;

3. Skilled and intermediate long term care facilities licensed under the Nursing Home Care Act;

3. Skilled and intermediate long term care facilities

licensed under the Nursing Home Care Act;

4. Hospitals, nursing homes, ambulatory surgical treatment centers, or kidney disease treatment centers maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit; and

6. An institution, place, building, or room used for the performance of outpatient surgical procedures that is leased, owned, or operated by or on behalf of an out-of-state facility.

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

No facility licensed under the Supportive Residences Licensing Act or the Assisted Living and Shared Housing Act shall be subject to the provisions of this Act.

A facility designated as a supportive living facility that is in good standing with the demonstration project established under Section 5-5.01a of the Illinois Public Aid Code shall not be subject to the provisions of this Act.

This Act does not apply to facilities granted waivers under Section 3-102.2 of the Nursing Home Care Act. However, if a demonstration project under that Act applies for a certificate of need to convert to a nursing facility, it shall meet the licensure and certificate of need requirements in effect as of the date of application.

This Act shall not apply to the closure of an entity or a portion of an entity licensed under the Nursing Home Care Act that elects to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care

professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" means the Health Facilities Planning Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility

administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion or transition project undertaken in accordance with Section 25 or 30 of the Comprehensive Housing, Health, and Supportive Services for Older Adults Act shall be excluded from any obligations under this Act.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies,

surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $6,000,000, which shall be annually adjusted to reflect the increase in construction costs due to inflation, for major medical equipment and for all other capital expenditures; provided, however, that when a capital expenditure is for the construction or modification of a health and fitness center, "capital expenditure minimum" means the capital expenditure minimum for all other capital expenditures in effect on March 1, 2000, which shall be annually adjusted to reflect the increase in construction costs due to inflation.

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and

storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with the term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Areawide health planning organization" or "Comprehensive health planning organization" means the health systems agency designated by the Secretary, Department of Health and Human Services or any successor agency.

"Local health planning organization" means those local health planning organizations that are designated as such by the areawide health planning organization of the appropriate area.

"Physician" means a person licensed to practice in accordance with the Medical Practice Act of 1987, as amended.

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Comprehensive health planning" means health planning concerned with the total population and all health and associated problems that affect the well-being of people and that encompasses health services, health manpower, and health

facilities; and the coordination among these and with those social, economic, and environmental factors that affect health.

"Alternative health care model" means a facility or program authorized under the Alternative Health Care Delivery Act.

"Out-of-state facility" means a person that is both (i) licensed as a hospital or as an ambulatory surgery center under the laws of another state or that qualifies as a hospital or an ambulatory surgery center under regulations adopted pursuant to the Social Security Act and (ii) not licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act. Affiliates of out-of-state facilities shall be considered out-of-state facilities. Affiliates of Illinois licensed health care facilities 100% owned by an Illinois licensed health care facility, its parent, or Illinois physicians licensed to practice medicine in all its branches shall not be considered out-of-state facilities. Nothing in this definition shall be construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

"Change of ownership of a health care facility" means a change in the person who has ownership or control of a health care facility's physical plant and capital assets. A change in ownership is indicated by the following transactions: sale, transfer, acquisition, lease, change of sponsorship, or other means of transferring control.

"Related person" means any person that: (i) is at least 50% owned, directly or indirectly, by either the health care facility or a person owning, directly or indirectly, at least 50% of the health care facility; or (ii) owns, directly or indirectly, at least 50% of the health care facility.

(Source: P.A. 93-41, eff. 6-27-03.)

Section 95. The State Finance Act is amended by adding

Sections 5.621, 5.622, and 5.623 and changing Section 8h as follows:

(30 ILCS 105/5.621 new)

Sec. 5.621. The Nursing Home Conversion Fund.

(30 ILCS 105/5.622 new)

Sec. 5.622. The Nursing Home Transition Planning Grant Fund.

(30 ILCS 105/5.623 new)

Sec. 5.623. The Long-Term Care Services for Older Adults Fund.

(30 ILCS 105/8h)

Sec. 8h. Transfers to General Revenue Fund.

(a) Except as provided in subsection (b), notwithstanding ~~Notwithstanding~~ any other State law to the contrary, the Director of the Governor's Office of Management and Budget may from time to time direct the State Treasurer and Comptroller to transfer a specified sum from any fund held by the State Treasurer to the General Revenue Fund in order to help defray the State's operating costs for the fiscal year. The total transfer under this Section from any fund in any fiscal year shall not exceed the lesser of 8% of the revenues to be deposited into the fund during that year or 25% of the beginning balance in the fund. No transfer may be made from a fund under this Section that would have the effect of reducing the available balance in the fund to an amount less than the amount remaining unexpended and unreserved from the total appropriation from that fund for that fiscal year. This Section does not apply to any funds that are restricted by federal law to a specific use or to any funds in the Motor Fuel Tax Fund or the Hospital Provider Fund. Notwithstanding any other provision of this Section, the total transfer under this Section from the Road Fund or the State Construction Account

Fund shall not exceed 5% of the revenues to be deposited into the fund during that year.

In determining the available balance in a fund, the Director of the Governor's Office of Management and Budget may include receipts, transfers into the fund, and other resources anticipated to be available in the fund in that fiscal year.

The State Treasurer and Comptroller shall transfer the amounts designated under this Section as soon as may be practicable after receiving the direction to transfer from the Director of the Governor's Office of Management and Budget.

(b) This Section does not apply to the Nursing Home Conversion Fund, the Nursing Home Transition Planning Grant Fund, or the Long-Term Care Services for Older Adults Fund.

(Source: P.A. 93-32, eff. 6-20-03; 93-659, eff. 2-3-04.)

Section 96. The Nursing Home Care Act is amended by changing Section 3-103 as follows:

(210 ILCS 45/3-103) (from Ch. 111 1/2, par. 4153-103)

Sec. 3-103. The procedure for obtaining a valid license shall be as follows:

(1) Application to operate a facility shall be made to the Department on forms furnished by the Department.

(2) All license applications shall be accompanied with an application fee. The fee for an annual license shall be based on the licensed capacity of the facility and shall be determined as follows: 0-49 licensed beds, a flat fee of $500; 50-99 licensed beds, a flat fee of $750; and for any facility with 100 or more licensed beds, a fee of $1,000 plus $10 per licensed bed. The fee for a 2-year license shall be double the fee for the annual license set forth in the preceding sentence. The first $600,000 of such fees collected each fiscal year shall be deposited with the State Treasurer into the Long Term Care Monitor/Receiver Fund, which has been created as a special fund in the State treasury. Any such fees in excess of $600,000 collected in a fiscal year shall be deposited into the General

Revenue Fund. This special fund is to be used by the Department for expenses related to the appointment of monitors and receivers as contained in Sections 3-501 through 3-517. At the end of each fiscal year, any funds in excess of $1,000,000 held in the Long Term Care Monitor/Receiver Fund <u>after transfers to the Nursing Home Conversion Fund and the Nursing Home Transition Planning Grant Fund as provided in the Comprehensive Housing, Health, and Supportive Services for Older Adults Act</u> shall be deposited in the State's General Revenue Fund. The application shall be under oath and the submission of false or misleading information shall be a Class A misdemeanor. The application shall contain the following information:

(a) The name and address of the applicant if an individual, and if a firm, partnership, or association, of every member thereof, and in the case of a corporation, the name and address thereof and of its officers and its registered agent, and in the case of a unit of local government, the name and address of its chief executive officer;

(b) The name and location of the facility for which a license is sought;

(c) The name of the person or persons under whose management or supervision the facility will be conducted;

(d) The number and type of residents for which maintenance, personal care, or nursing is to be provided; and

(e) Such information relating to the number, experience, and training of the employees of the facility, any management agreements for the operation of the facility, and of the moral character of the applicant and employees as the Department may deem necessary.

(3) Each initial application shall be accompanied by a financial statement setting forth the financial condition of the applicant and by a statement from the unit of local government having zoning jurisdiction over the facility's location stating that the location of the facility is not in

violation of a zoning ordinance. An initial application for a new facility shall be accompanied by a permit as required by the "Illinois Health Facilities Planning Act". After the application is approved, the applicant shall advise the Department every 6 months of any changes in the information originally provided in the application.

(4) Other information necessary to determine the identity and qualifications of an applicant to operate a facility in accordance with this Act shall be included in the application as required by the Department in regulations.

(Source: P.A. 93-32, eff. 7-1-03.)

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