Sen. Napoleon Harris, III

Filed: 5/19/2016

AMENDMENT TO HOUSE BILL 4517

AMENDMENT NO. _____. Amend House Bill 4517 by replacing everything after the enacting clause with the following:

"Section 5. The Civil Administrative Code of Illinois is amended by changing Section 5-565 as follows:

(20 ILCS 5/5-565) (was 20 ILCS 5/6.06)

Sec. 5-565. In the Department of Public Health.

(a) The General Assembly declares it to be the public policy of this State that all citizens of Illinois are entitled to lead healthy lives. Governmental public health has a specific responsibility to ensure that a public health system is in place to allow the public health mission to be achieved. The public health system is the collection of public, private, and voluntary entities as well as individuals and informal associations that contribute to the public's health within the State. To develop a public health system requires certain core

functions to be performed by government. The State Board of Health is to assume the leadership role in advising the Director in meeting the following functions:

(1) Needs assessment.

(2) Statewide health objectives.

(3) Policy development.

(4) Assurance of access to necessary services.

There shall be a State Board of Health composed of 20 persons, all of whom shall be appointed by the Governor, with the advice and consent of the Senate for those appointed by the Governor on and after June 30, 1998, and one of whom shall be a senior citizen age 60 or over. Five members shall be physicians licensed to practice medicine in all its branches, one representing a medical school faculty, one who is board certified in preventive medicine, and one who is engaged in private practice. One member shall be a chiropractic physician. One member shall be a dentist; one an environmental health practitioner; one a local public health administrator; one a local board of health member; one a registered nurse; one a physical therapist; one an optometrist; one a veterinarian; one a public health academician; one a health care industry representative; one a representative of the business community; one a representative of the non-profit public interest community; and 2 shall be citizens at large.

The terms of Board of Health members shall be 3 years, except that members shall continue to serve on the Board of

Health until a replacement is appointed. Upon the effective date of this amendatory Act of the 93rd General Assembly, in the appointment of the Board of Health members appointed to vacancies or positions with terms expiring on or before December 31, 2004, the Governor shall appoint up to 6 members to serve for terms of 3 years; up to 6 members to serve for terms of 2 years; and up to 5 members to serve for a term of one year, so that the term of no more than 6 members expire in the same year. All members shall be legal residents of the State of Illinois. The duties of the Board shall include, but not be limited to, the following:

(1) To advise the Department of ways to encourage public understanding and support of the Department's programs.

(2) To evaluate all boards, councils, committees, authorities, and bodies advisory to, or an adjunct of, the Department of Public Health or its Director for the purpose of recommending to the Director one or more of the following:

(i) The elimination of bodies whose activities are not consistent with goals and objectives of the Department.

(ii) The consolidation of bodies whose activities encompass compatible programmatic subjects.

(iii) The restructuring of the relationship between the various bodies and their integration

within the organizational structure of the Department.

(iv) The establishment of new bodies deemed essential to the functioning of the Department.

(3) To serve as an advisory group to the Director for public health emergencies and control of health hazards.

(4) To advise the Director regarding public health policy, and to make health policy recommendations regarding priorities to the Governor through the Director.

(5) To present public health issues to the Director and to make recommendations for the resolution of those issues.

(6) To recommend studies to delineate public health problems.

(7) To make recommendations to the Governor through the Director regarding the coordination of State public health activities with other State and local public health agencies and organizations.

(8) To report on or before February 1 of each year on the health of the residents of Illinois to the Governor, the General Assembly, and the public.

(9) To review the final draft of all proposed administrative rules, other than emergency or preemptory rules and those rules that another advisory body must approve or review within a statutorily defined time period, of the Department after September 19, 1991 (the effective date of Public Act 87-633). The Board shall review the proposed rules within 90 days of submission by the

Department. The Department shall take into consideration any comments and recommendations of the Board regarding the proposed rules prior to submission to the Secretary of State for initial publication. If the Department disagrees with the recommendations of the Board, it shall submit a written response outlining the reasons for not accepting the recommendations.

In the case of proposed administrative rules or amendments to administrative rules regarding immunization of children against preventable communicable diseases designated by the Director under the Communicable Disease Prevention Act, after the Immunization Advisory Committee has made its recommendations, the Board shall conduct 3 public hearings, geographically distributed throughout the State. At the conclusion of the hearings, the State Board of Health shall issue a report, including its recommendations, to the Director. The Director shall take into consideration any comments or recommendations made by the Board based on these hearings.

(10) To deliver to the Governor for presentation to the General Assembly a State Health Improvement Plan. The first 3 such plans shall be delivered to the Governor on January 1, 2006, January 1, 2009, and January 1, 2016 and then every 5 years thereafter.

The Plan shall recommend priorities and strategies to improve the public health system and the health status of

Illinois residents, taking into consideration national health objectives and system standards as frameworks for assessment.

The Plan shall also take into consideration priorities and strategies developed at the community level through the Illinois Project for Local Assessment of Needs (IPLAN) and any regional health improvement plans that may be developed. The Plan shall focus on prevention as a key strategy for long-term health improvement in Illinois.

The Plan shall examine and make recommendations on the contributions and strategies of the public and private sectors for improving health status and the public health system in the State. In addition to recommendations on health status improvement priorities and strategies for the population of the State as a whole, the Plan shall make recommendations regarding priorities and strategies for reducing and eliminating health disparities in Illinois; including racial, ethnic, gender, age, socio-economic and geographic disparities.

The Director of the Illinois Department of Public Health shall appoint a Planning Team that includes a range of public, private, and voluntary sector stakeholders and participants in the public health system. This Team shall include: the directors of State agencies with public health responsibilities (or their designees), including but not limited to the Illinois Departments of Public Health and

Department of Human Services, representatives of local health departments, representatives of local community health partnerships, and individuals with expertise who represent an array of organizations and constituencies engaged in public health improvement and prevention.

The State Board of Health shall hold at least 3 public hearings addressing drafts of the Plan in representative geographic areas of the State. Members of the Planning Team shall receive no compensation for their services, but may be reimbursed for their necessary expenses.

Upon the delivery of each State Health Improvement Plan, the Governor shall appoint a SHIP Implementation Coordination Council that includes a range of public, private, and voluntary sector stakeholders and participants in the public health system. The Council shall include the directors of State agencies and entities with public health system responsibilities (or their designees), including but not limited to the Department of Public Health, Department of Human Services, Department of Healthcare and Family Services, Environmental Protection Agency, Illinois State Board of Education, Department on Aging, Illinois Violence Prevention Authority, Department of Agriculture, Department of Insurance, Department of Financial and Professional Regulation, Department of Transportation, and Department of Commerce and Economic Opportunity and the Chair of the State Board of Health. The

Council shall include representatives of local health departments and individuals with expertise who represent an array of organizations and constituencies engaged in public health improvement and prevention, including non-profit public interest groups, health issue groups, faith community groups, health care providers, businesses and employers, academic institutions, and community-based organizations. The Governor shall endeavor to make the membership of the Council representative of the racial, ethnic, gender, socio-economic, and geographic diversity of the State. The Governor shall designate one State agency representative and one other non-governmental member as co-chairs of the Council. The Governor shall designate a member of the Governor's office to serve as liaison to the Council and one or more State agencies to provide or arrange for support to the Council. The members of the SHIP Implementation Coordination Council for each State Health Improvement Plan shall serve until the delivery of the subsequent State Health Improvement Plan, whereupon a new Council shall be appointed. Members of the SHIP Planning Team may serve on the SHIP Implementation Coordination Council if so appointed by the Governor.

The SHIP Implementation Coordination Council shall coordinate the efforts and engagement of the public, private, and voluntary sector stakeholders and participants in the public health system to implement each

SHIP. The Council shall serve as a forum for collaborative action; coordinate existing and new initiatives; develop detailed implementation steps, with mechanisms for action; implement specific projects; identify public and private funding sources at the local, State and federal level; promote public awareness of the SHIP; advocate for the implementation of the SHIP; and develop an annual report to the Governor, General Assembly, and public regarding the status of implementation of the SHIP. The Council shall not, however, have the authority to direct any public or private entity to take specific action to implement the SHIP.

(11) Upon the request of the Governor, to recommend to the Governor candidates for Director of Public Health when vacancies occur in the position.

(12) To adopt bylaws for the conduct of its own business, including the authority to establish ad hoc committees to address specific public health programs requiring resolution.

(13) (Blank). ~~To review and comment upon the Comprehensive Health Plan submitted by the Center for Comprehensive Health Planning as provided under Section 2310-217 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois.~~

Upon appointment, the Board shall elect a chairperson from among its members.

Members of the Board shall receive compensation for their services at the rate of $150 per day, not to exceed $10,000 per year, as designated by the Director for each day required for transacting the business of the Board and shall be reimbursed for necessary expenses incurred in the performance of their duties. The Board shall meet from time to time at the call of the Department, at the call of the chairperson, or upon the request of 3 of its members, but shall not meet less than 4 times per year.

(b) (Blank).

(c) An Advisory Board on Necropsy Service to Coroners, which shall counsel and advise with the Director on the administration of the Autopsy Act. The Advisory Board shall consist of 11 members, including a senior citizen age 60 or over, appointed by the Governor, one of whom shall be designated as chairman by a majority of the members of the Board. In the appointment of the first Board the Governor shall appoint 3 members to serve for terms of 1 year, 3 for terms of 2 years, and 3 for terms of 3 years. The members first appointed under Public Act 83-1538 shall serve for a term of 3 years. All members appointed thereafter shall be appointed for terms of 3 years, except that when an appointment is made to fill a vacancy, the appointment shall be for the remaining term of the position vacant. The members of the Board shall be citizens of the State of Illinois. In the appointment of members of the Advisory Board the Governor shall appoint 3 members who shall

be persons licensed to practice medicine and surgery in the State of Illinois, at least 2 of whom shall have received post-graduate training in the field of pathology; 3 members who are duly elected coroners in this State; and 5 members who shall have interest and abilities in the field of forensic medicine but who shall be neither persons licensed to practice any branch of medicine in this State nor coroners. In the appointment of medical and coroner members of the Board, the Governor shall invite nominations from recognized medical and coroners organizations in this State respectively. Board members, while serving on business of the Board, shall receive actual necessary travel and subsistence expenses while so serving away from their places of residence.
(Source: P.A. 97-734, eff. 1-1-13; 97-810, eff. 1-1-13; 98-463, eff. 8-16-13.)

Section 10. The Illinois Health Facilities Planning Act is amended by changing Sections 2, 3, 4, 8.5, 10, 12, 12.2, 12.3, 14.1, and 19.5 as follows:

(20 ILCS 3960/2) (from Ch. 111 1/2, par. 1152)

(Section scheduled to be repealed on December 31, 2019)

Sec. 2. Purpose of the Act. This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and

financial resources to adequately provide a proper service for the community; (2) that promotes~~, through the process of comprehensive health planning,~~ the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; and (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs~~; and (4) that carries out these purposes in coordination with the Center for Comprehensive Health Planning and the Comprehensive Health Plan developed by that Center~~.

The changes made to this Act by this amendatory Act of the 96th General Assembly are intended to accomplish the following objectives: to improve the financial ability of the public to obtain necessary health services; to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; to maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent; to assure that the reduction and closure of health care services or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public; and to assess the financial burden to patients caused by unnecessary health care construction and modification. ~~The Health Facilities and Services Review Board must apply the~~

~~findings from the Comprehensive Health Plan to update review standards and criteria, as well as better identify needs and evaluate applications, and establish mechanisms to support adequate financing of the health care delivery system in Illinois, for the development and preservation of safety net services. The Board must provide written and consistent decisions that are based on the findings from the Comprehensive Health Plan, as well as other issue or subject specific plans, recommended by the Center for Comprehensive Health Planning. Policies and procedures must include criteria and standards for plan variations and deviations that must be updated.~~ Evidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois. The integrity of the Certificate of Need process is ensured through revised ethics and communications procedures. Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process.

(Source: P.A. 96-31, eff. 6-30-09.)

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

(Section scheduled to be repealed on December 31, 2019)

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

"Health care facilities" means and includes the following facilities, organizations, and related persons:

(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.

(A) If a demonstration project under the Nursing Home Care 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.

(B) Except as provided in item (A) of this subsection, this Act does not apply to facilities granted waivers under Section 3-102.2 of the Nursing Home Care Act.

(3.5) Skilled and intermediate care facilities licensed under the ID/DD Community Care Act or the MC/DD Act. No permit or exemption is required for a facility licensed under the ID/DD Community Care Act or the MC/DD Act prior to the reduction of the number of beds at a facility. If there is a total reduction of beds at a facility licensed under the ID/DD Community Care Act or the MC/DD Act, this is a discontinuation or closure of the facility. If a facility licensed under the ID/DD Community Care Act or the MC/DD Act reduces the number of beds or

discontinues the facility, that facility must notify the Board as provided in Section 14.1 of this Act.

(3.7) Facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013.

(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 required to be licensed under the End Stage Renal Disease Facility Act.

(A) This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis.

(B) This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home.

(C) The Board, however, may require dialysis facilities and licensed nursing homes under items (A) and (B) of this subsection to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.

(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.

(7) An institution, place, building, or room used for provision of a health care category of service, including, but not limited to, cardiac catheterization and open heart surgery.

(8) An institution, place, building, or room housing major medical equipment used in the direct clinical diagnosis or treatment of patients, and whose project cost is in excess of the capital expenditure minimum.

"Health care facilities" does not include the following entities or facility transactions:

(1) Federally-owned facilities.

(2) Facilities used solely for healing by prayer or spiritual means.

(3) An existing facility located on any campus facility as defined in Section 5-5.8b of the Illinois Public Aid Code, provided that the campus facility encompasses 30 or more contiguous acres and that the new or renovated facility is intended for use by a licensed residential facility.

(4) Facilities licensed under the Supportive Residences Licensing Act or the Assisted Living and Shared Housing Act.

(5) Facilities designated as supportive living facilities that are in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code.

(6) Facilities established and operating under the Alternative Health Care Delivery Act as a children's community-based health care center alternative health care model demonstration program or as an Alzheimer's Disease Management Center alternative health care model demonstration program.

(7) The closure of an entity or a portion of an entity licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the exception of facilities operated by a county or Illinois Veterans Homes, that elect to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act and with the exception of a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013 in connection with a proposal to close a facility and re-establish the facility in another location.

(8) Any change of ownership of a health care facility that is licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the

exception of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care 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, unless the entity constructs, modifies, or establishes a health care facility as specifically defined in this Section. 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" or "Board" means the Health Facilities and Services Review 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 project undertaken in accordance with Section 30 of the Older Adult Services 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 or the initiation of a category of service.

"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. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. 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 $11,500,000 for projects by hospital applicants, $6,500,000 for applicants for projects related to skilled and intermediate care long-term

care facilities licensed under the Nursing Home Care Act, and $3,000,000 for projects by all other applicants, 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.

"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".

"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" <u>or "Department"</u> means the Illinois Department of Public 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.

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer.

"Freestanding emergency center" means a facility subject to licensure under Section 32.5 of the Emergency Medical

Services (EMS) Systems Act.

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice of a physician or other licensed health care professional while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

"State Board Staff Report" means the document that sets forth the review and findings of the State Board staff, as prescribed by the State Board, regarding applications subject to Board jurisdiction.

(Source: P.A. 98-414, eff. 1-1-14; 98-629, eff. 1-1-15; 98-651, eff. 6-16-14; 98-1086, eff. 8-26-14; 99-78, eff. 7-20-15; 99-180, eff. 7-29-15.)

(20 ILCS 3960/4) (from Ch. 111 1/2, par. 1154)

(Section scheduled to be repealed on December 31, 2019)

Sec. 4. Health Facilities and Services Review Board; membership; appointment; term; compensation; quorum.

Notwithstanding any other provision in this Section, members of the State Board holding office on the day before the effective date of this amendatory Act of the 96th General Assembly shall retain their authority.

(a) There is created the Health Facilities and Services Review Board, which shall perform the functions described in this Act. The Department shall provide operational support to the Board as necessary, including the provision of office space, supplies, and clerical, financial, and accounting services. The Board may contract for functions or operational support as needed. The Board may also contract with experts related to specific health services or facilities and create technical advisory panels to assist in the development of criteria, standards, and procedures used in the evaluation of applications for permit and exemption.

(b) Beginning March 1, 2010, the State Board shall consist of 9 voting members. All members shall be residents of Illinois and at least 4 shall reside outside the Chicago Metropolitan Statistical Area. Consideration shall be given to potential appointees who reflect the ethnic and cultural diversity of the State. Neither Board members nor Board staff shall be convicted felons or have pled guilty to a felony.

Each member shall have a reasonable knowledge of the practice, procedures and principles of the health care delivery system in Illinois, including at least 5 members who shall be knowledgeable about health care delivery systems, health

systems planning, finance, or the management of health care facilities currently regulated under the Act. One member shall be a representative of a non-profit health care consumer advocacy organization. A spouse, parent, sibling, or child of a Board member cannot be an employee, agent, or under contract with services or facilities subject to the Act. Prior to appointment and in the course of service on the Board, members of the Board shall disclose the employment or other financial interest of any other relative of the member, if known, in service or facilities subject to the Act. Members of the Board shall declare any conflict of interest that may exist with respect to the status of those relatives and recuse themselves from voting on any issue for which a conflict of interest is declared. No person shall be appointed or continue to serve as a member of the State Board who is, or whose spouse, parent, sibling, or child is, a member of the Board of Directors of, has a financial interest in, or has a business relationship with a health care facility.

Notwithstanding any provision of this Section to the contrary, the term of office of each member of the State Board serving on the day before the effective date of this amendatory Act of the 96th General Assembly is abolished on the date upon which members of the 9-member Board, as established by this amendatory Act of the 96th General Assembly, have been appointed and can begin to take action as a Board. Members of the State Board serving on the day before the effective date of

this amendatory Act of the 96th General Assembly may be reappointed to the 9-member Board. Prior to March 1, 2010, the Health Facilities Planning Board shall establish a plan to transition its powers and duties to the Health Facilities and Services Review Board.

(c) The State Board shall be appointed by the Governor, with the advice and consent of the Senate. Not more than 5 of the appointments shall be of the same political party at the time of the appointment.

The Secretary of Human Services, the Director of Healthcare and Family Services, and the Director of Public Health, or their designated representatives, shall serve as ex-officio, non-voting members of the State Board.

(d) Of those 9 members initially appointed by the Governor following the effective date of this amendatory Act of the 96th General Assembly, 3 shall serve for terms expiring July 1, 2011, 3 shall serve for terms expiring July 1, 2012, and 3 shall serve for terms expiring July 1, 2013. Thereafter, each appointed member shall hold office for a term of 3 years, provided that 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 such term and the term of office of each successor shall commence on July 1 of the year in which his predecessor's term expires. Each member appointed after the effective date of this amendatory Act of the 96th General Assembly shall hold office

until his or her successor is appointed and qualified. The Governor may reappoint a member for additional terms, but no member shall serve more than 3 terms, subject to review and re-approval every 3 years.

(e) State Board members, while serving on business of the State Board, shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. Until March 1, 2010, a member of the State Board who experiences a significant financial hardship due to the loss of income on days of attendance at meetings or while otherwise engaged in the business of the State Board may be paid a hardship allowance, as determined by and subject to the approval of the Governor's Travel Control Board.

(f) The Governor shall designate one of the members to serve as the Chairman of the Board, who shall be a person with expertise in health care delivery system planning, finance or management of health care facilities that are regulated under the Act. The Chairman shall annually review Board member performance and shall report the attendance record of each Board member to the General Assembly.

(g) The State Board, through the Chairman, shall prepare a separate and distinct budget approved by the General Assembly and shall hire and supervise its own professional staff responsible for carrying out the responsibilities of the Board.

(h) The State Board shall meet at least every 45 days, or as often as the Chairman of the State Board deems necessary, or

upon the request of a majority of the members.

(i) Five members of the State Board shall constitute a quorum. The affirmative vote of 5 of the members of the State Board shall be necessary for any action requiring a vote to be taken by the State Board. A vacancy in the membership of the State Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the State Board as provided by this Act.

(j) A State Board member shall disqualify himself or herself from the consideration of any application for a permit or exemption in which the State Board member or the State Board member's spouse, parent, sibling, or child: (i) has an economic interest in the matter; or (ii) is employed by, serves as a consultant for, or is a member of the governing board of the applicant or a party opposing the application.

(k) The Chairman, Board members, and Board staff must comply with the Illinois Governmental Ethics Act.

(Source: P.A. 96-31, eff. 6-30-09; 97-1115, eff. 8-27-12.)

(20 ILCS 3960/8.5)

(Section scheduled to be repealed on December 31, 2019)

Sec. 8.5. Certificate of exemption for change of ownership of a health care facility; discontinuation of a health care facility or category of service; public notice and public hearing.

(a) Upon a finding that an application for a change of

ownership is complete, the State Board shall publish a legal notice on one day in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on one day. The applicant shall pay the cost incurred by the Board in publishing the change of ownership notice in newspapers as required under this subsection. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. An application for change of ownership of a hospital shall not be deemed complete without a signed certification that for a period of 2 years after the change of ownership transaction is effective, the hospital will not adopt a charity care policy that is more restrictive than the policy in effect during the year prior to the transaction. An application for a change of ownership need not contain signed transaction documents so long as it includes the following key terms of the transaction: names and background of the parties; structure of the transaction; the person who will be the licensed or certified entity after the transaction; the

ownership or membership interests in such licensed or certified entity both prior to and after the transaction; fair market value of assets to be transferred; and the purchase price or other form of consideration to be provided for those assets. The issuance of the certificate of exemption shall be contingent upon the applicant submitting a statement to the Board within 90 days after the closing date of the transaction, or such longer period as provided by the Board, certifying that the change of ownership has been completed in accordance with the key terms contained in the application. If such key terms of the transaction change, a new application shall be required.

Where a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under this Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership. Once such an application is submitted to the Board and reviewed by the Board staff, the Board Chair shall take action on an application for an exemption for a change of ownership among related persons within 45 days after the application has been deemed complete, provided the application meets the applicable standards under this Section. If the Board Chair has a conflict of interest or for other good cause, the Chair may request review by the Board. Notwithstanding any other provision of this Act, for purposes of this Section, a

change of ownership among related persons means a transaction where the parties to the transaction are under common control or ownership before and after the transaction is completed.

Nothing in this Act shall be construed as authorizing the Board to impose any conditions, obligations, or limitations, other than those required by this Section, with respect to the issuance of an exemption for a change of ownership, including, but not limited to, the time period before which a subsequent change of ownership of the health care facility could be sought, or the commitment to continue to offer for a specified time period any services currently offered by the health care facility.

(a-3) Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which

the health care facility is located. No later than 90 days after a discontinuation of a health facility, the applicant must submit a statement to the State Board certifying that the discontinuation is complete.

(a-5) Upon a finding that an application to discontinue a category of service is complete and provides the requested information, as specified by the State Board, an exemption shall be issued. No later than 30 days after the issuance of the exemption, the health care facility must give written notice of the discontinuation of the category of service to the State Senator and State Representative serving the legislative district in which the health care facility is located. No later than 90 days after a discontinuation of a category of service, the applicant must submit a statement to the State Board certifying that the discontinuation is complete.

(b) If a public hearing is requested, it shall be held at least 15 days but no more than 30 days after the date of publication of the legal notice in the community in which the facility is located. The hearing shall be held in a place of reasonable size and accessibility and a full and complete written transcript of the proceedings shall be made. All interested persons attending the hearing shall be given a reasonable opportunity to present their positions in writing or orally. The applicant shall provide a summary of the proposal for distribution at the public hearing.

(c) For the purposes of this Section "newspaper of limited

circulation" means a newspaper intended to serve a particular or defined population of a specific geographic area within a Metropolitan Statistical Area such as a municipality, town, village, township, or community area, but does not include publications of professional and trade associations.

(Source: P.A. 98-1086, eff. 8-26-14; 99-154, eff. 7-28-15.)

(20 ILCS 3960/10) (from Ch. 111 1/2, par. 1160)

(Section scheduled to be repealed on December 31, 2019)

Sec. 10. Presenting information relevant to the approval of a permit or certificate or in opposition to the denial of the application; notice of outcome and review proceedings. When a motion by the State Board, to approve an application for a permit ~~or a certificate of recognition~~, fails to pass, or when a motion to deny an application for a permit ~~or a certificate of recognition~~ is passed, the applicant or the holder of the permit, as the case may be, and such other parties as the State Board permits, will be given an opportunity to appear before the State Board and present such information as may be relevant to the approval of a permit ~~or certificate~~ or in opposition to the denial of the application.

Subsequent to an appearance by the applicant before the State Board or default of such opportunity to appear, a motion by the State Board to approve an application for a permit ~~or a certificate of recognition~~ which fails to pass or a motion to deny an application for a permit ~~or a certificate of~~

~~recognition~~ which passes shall be considered denial of the application for a permit ~~or certificate of recognition~~, as the case may be. Such action of denial or an action by the State Board to revoke a permit ~~or a certificate of recognition~~ shall be communicated to the applicant or holder of the permit ~~or certificate of recognition~~. Such person or organization shall be afforded an opportunity for a hearing before an administrative law judge, who is appointed by the Chairman of the State Board. A written notice of a request for such hearing shall be served upon the Chairman of the State Board within 30 days following notification of the decision of the State Board. The administrative law judge shall take actions necessary to ensure that the hearing is completed within a reasonable period of time, but not to exceed 120 days, except for delays or continuances agreed to by the person requesting the hearing. Following its consideration of the report of the hearing, or upon default of the party to the hearing, the State Board shall make its final determination, specifying its findings and conclusions within 90 days of receiving the written report of the hearing. A copy of such determination shall be sent by certified mail or served personally upon the party.

A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the State Board or hearing officer. All testimony shall be reported

but need not be transcribed unless the decision is appealed in accordance with the Administrative Review Law, as now or hereafter amended. A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

The State Board or hearing officer shall upon its own or his motion, or on the written request of any party to the proceeding who has, in the State Board's or hearing officer's opinion, demonstrated the relevancy of such request to the outcome of the proceedings, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records, or memoranda. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the circuit court of this State.

When the witness is subpoenaed at the instance of the State Board, or its hearing officer, such fees shall be paid in the same manner as other expenses of the Board, and when the witness is subpoenaed at the instance of any other party to any such proceeding the State Board may, in accordance with its rules, require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness is summoned. In such case, the State Board in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum so issued shall be served in the same

manner as a subpoena issued out of a court.

Any circuit court of this State upon the application of the State Board or upon the application of any other party to the proceeding, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before it or its hearing officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

(Source: P.A. 97-1115, eff. 8-27-12; 98-1086, eff. 8-26-14.)

(20 ILCS 3960/12) (from Ch. 111 1/2, par. 1162)

(Section scheduled to be repealed on December 31, 2019)

Sec. 12. Powers and duties of State Board. For purposes of this Act, the State Board shall exercise the following powers and duties:

(1) Prescribe rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of project reviewed and which are required to carry out the provisions and purposes of this Act. Policies and procedures of the State Board shall take into consideration the priorities and needs of medically underserved areas and other health care services ~~identified through the comprehensive health planning process~~, giving special consideration to the impact of projects

on access to safety net services.

(2) Adopt procedures for public notice and hearing on all proposed rules, regulations, standards, criteria, and plans required to carry out the provisions of this Act.

(3) (Blank).

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, maintain an updated inventory on the Board's web site reflecting the most recent bed and service changes and updated need determinations when new census data become available or new need formulae are adopted, and develop health care facility plans which shall be utilized in the review of applications for permit under this Act. Such health facility plans shall be coordinated by the Board with pertinent State Plans. Inventories pursuant to this Section of skilled or intermediate care facilities licensed under the Nursing Home Care Act, skilled or intermediate care facilities licensed under the ID/DD Community Care Act, skilled or intermediate care facilities licensed under the MC/DD Act, facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013, or nursing homes licensed under the Hospital Licensing Act shall be conducted on an annual basis no later than July 1 of each year and shall include among the information requested a list of all services provided by a facility to its residents and to the community at large and differentiate between active and inactive beds.

In developing health care facility plans, the State Board shall consider, but shall not be limited to, the following:

(a) The size, composition and growth of the population of the area to be served;

(b) The number of existing and planned facilities offering similar programs;

(c) The extent of utilization of existing facilities;

(d) The availability of facilities which may serve as alternatives or substitutes;

(e) The availability of personnel necessary to the operation of the facility;

(f) Multi-institutional planning and the establishment of multi-institutional systems where feasible;

(g) The financial and economic feasibility of proposed construction or modification; and

(h) In the case of health care facilities established by a religious body or denomination, the needs of the members of such religious body or denomination may be considered to be public need.

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

(5) Coordinate with ~~the Center for Comprehensive Health Planning and~~ other state agencies having responsibilities affecting health care facilities, including those of licensure

and cost reporting. ~~Beginning no later than January 1, 2013, the Department of Public Health shall produce a written annual report to the Governor and the General Assembly regarding the development of the Center for Comprehensive Health Planning. The Chairman of the State Board and the State Board Administrator shall also receive a copy of the annual report.~~

(6) Solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or property for use by the State Board ~~or Center for Comprehensive Health Planning~~ in the administration of this Act; and enter into contracts consistent with the appropriations for purposes enumerated in this Act.

(7) The State Board shall prescribe procedures for review, standards, and criteria which shall be utilized to make periodic reviews and determinations of the appropriateness of any existing health services being rendered by health care facilities subject to the Act. The State Board shall consider recommendations of the Board in making its determinations.

(8) Prescribe~~, in consultation with the Center for Comprehensive Health Planning,~~ rules, regulations, standards, and criteria for the conduct of an expeditious review of applications for permits for projects of construction or modification of a health care facility, which projects are classified as emergency, substantive, or non-substantive in nature.

Six months after June 30, 2009 (the effective date of

Public Act 96-31), substantive projects shall include no more than the following:

(a) Projects to construct (1) a new or replacement facility located on a new site or (2) a replacement facility located on the same site as the original facility and the cost of the replacement facility exceeds the capital expenditure minimum, which shall be reviewed by the Board within 120 days;

(b) Projects proposing a (1) new service within an existing healthcare facility or (2) discontinuation of a service within an existing healthcare facility, which shall be reviewed by the Board within 60 days; or

(c) Projects proposing a change in the bed capacity of a health care facility by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation of beds from one physical facility or site to another by more than 20 beds or more than 10% of total bed capacity, as defined by the State Board, whichever is less, over a 2-year period.

The Chairman may approve applications for exemption that meet the criteria set forth in rules or refer them to the full Board. The Chairman may approve any unopposed application that meets all of the review criteria or refer them to the full Board.

Such rules shall not ~~abridge the right of the Center for Comprehensive Health Planning to make recommendations on the~~

~~classification and approval of projects, nor shall such rules~~ prevent the conduct of a public hearing upon the timely request of an interested party. Such reviews shall not exceed 60 days from the date the application is declared to be complete.

(9) Prescribe rules, regulations, standards, and criteria pertaining to the granting of permits for construction and modifications which are emergent in nature and must be undertaken immediately to prevent or correct structural deficiencies or hazardous conditions that may harm or injure persons using the facility, as defined in the rules and regulations of the State Board. This procedure is exempt from public hearing requirements of this Act.

(10) Prescribe rules, regulations, standards and criteria for the conduct of an expeditious review, not exceeding 60 days, of applications for permits for projects to construct or modify health care facilities which are needed for the care and treatment of persons who have acquired immunodeficiency syndrome (AIDS) or related conditions.

(10.5) Provide its rationale when voting on an item before it at a State Board meeting in order to comply with subsection (b) of Section 3-108 of the Code of Civil Procedure.

(11) Issue written decisions upon request of the applicant or an adversely affected party to the Board. Requests for a written decision shall be made within 15 days after the Board meeting in which a final decision has been made. A "final decision" for purposes of this Act is the decision to approve

or deny an application, or take other actions permitted under this Act, at the time and date of the meeting that such action is scheduled by the Board. The transcript of the State Board meeting shall be incorporated into the Board's final decision. The staff of the Board shall prepare a written copy of the final decision and the Board shall approve a final copy for inclusion in the formal record. The Board shall consider, for approval, the written draft of the final decision no later than the next scheduled Board meeting. The written decision shall identify the applicable criteria and factors listed in this Act and the Board's regulations that were taken into consideration by the Board when coming to a final decision. If the Board denies or fails to approve an application for permit or exemption, the Board shall include in the final decision a detailed explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill.

(12) Require at least one of its members to participate in any public hearing, after the appointment of a majority of the members to the Board.

(13) Provide a mechanism for the public to comment on, and request changes to, draft rules and standards.

(14) Implement public information campaigns to regularly inform the general public about the opportunity for public hearings and public hearing procedures.

(15) Establish a separate set of rules and guidelines for

long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities. An open and transparent process shall be developed that considers the following: how skilled nursing fits in the continuum of care with other care providers, modernization of nursing homes, establishment of more private rooms, development of alternative services, and current trends in long-term care services. The Chairman of the Board shall appoint a permanent Health Services Review Board Long-term Care Facility Advisory Subcommittee that shall develop and recommend to the Board the rules to be established by the Board under this paragraph (15). The Subcommittee shall also provide continuous review and commentary on policies and procedures relative to long-term care and the review of related projects. The Subcommittee shall make recommendations to the Board no later than January 1, 2016 and every January thereafter pursuant to the Subcommittee's responsibility for the continuous review and commentary on policies and procedures relative to long-term care. In consultation with other experts from the health field of long-term care, the Board and the Subcommittee shall study new approaches to the current bed need formula and Health Service Area boundaries to encourage flexibility and innovation in design models reflective of the changing long-term care marketplace and consumer preferences and submit its recommendations to the Chairman of the Board no later than January 1, 2017. The Subcommittee shall evaluate,

and make recommendations to the State Board regarding, the buying, selling, and exchange of beds between long-term care facilities within a specified geographic area or drive time. The Board shall file the proposed related administrative rules for the separate rules and guidelines for long-term care required by this paragraph (15) by no later than September 30, 2011. The Subcommittee shall be provided a reasonable and timely opportunity to review and comment on any review, revision, or updating of the criteria, standards, procedures, and rules used to evaluate project applications as provided under Section 12.3 of this Act.

The Chairman of the Board shall appoint voting members of the Subcommittee, who shall serve for a period of 3 years, with one-third of the terms expiring each January, to be determined by lot. Appointees shall include, but not be limited to, recommendations from each of the 3 statewide long-term care associations, with an equal number to be appointed from each. Compliance with this provision shall be through the appointment and reappointment process. All appointees serving as of April 1, 2015 shall serve to the end of their term as determined by lot or until the appointee voluntarily resigns, whichever is earlier.

One representative from the Department of Public Health, the Department of Healthcare and Family Services, the Department on Aging, and the Department of Human Services may each serve as an ex-officio non-voting member of the

Subcommittee. The Chairman of the Board shall select a Subcommittee Chair, who shall serve for a period of 3 years.

(16) Prescribe the format of the State Board Staff Report. A State Board Staff Report shall pertain to applications that include, but are not limited to, applications for permit or exemption, applications for permit renewal, applications for extension of the obligation period, applications requesting a declaratory ruling, or applications under the Health Care Worker Self-Referral Act. State Board Staff Reports shall compare applications to the relevant review criteria under the Board's rules.

(17) Establish a separate set of rules and guidelines for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. An application for the re-establishment of a facility in connection with the relocation of the facility shall not be granted unless the applicant has a contractual relationship with at least one hospital to provide emergency and inpatient mental health services required by facility consumers, and at least one community mental health agency to provide oversight and assistance to facility consumers while living in the facility, and appropriate services, including case management, to assist them to prepare for discharge and reside stably in the community thereafter. No new facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall be established after June 16, 2014 (the effective date of Public

Act 98-651) except in connection with the relocation of an existing facility to a new location. An application for a new location shall not be approved unless there are adequate community services accessible to the consumers within a reasonable distance, or by use of public transportation, so as to facilitate the goal of achieving maximum individual self-care and independence. At no time shall the total number of authorized beds under this Act in facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 exceed the number of authorized beds on June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 98-414, eff. 1-1-14; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-1086, eff. 8-26-14; 99-78, eff. 7-20-15; 99-114, eff. 7-23-15; 99-180, eff. 7-29-15; 99-277, eff. 8-5-15; revised 10-15-15.)

(20 ILCS 3960/12.2)

(Section scheduled to be repealed on December 31, 2019)

Sec. 12.2. Powers of the State Board staff. For purposes of this Act, the staff shall exercise the following powers and duties:

(1) Review applications for permits and exemptions in accordance with the standards, criteria, and plans of need established by the State Board under this Act and certify its finding to the State Board.

(1.5) Post the following on the Board's web site: relevant

(i) rules, (ii) standards, (iii) criteria, (iv) State norms, (v) references used by Board staff in making determinations about whether application criteria are met, and (vi) notices of project-related filings, including notice of public comments related to the application.

(2) Charge and collect an amount determined by the State Board and the staff to be reasonable fees for the processing of applications by the State Board. The State Board shall set the amounts by rule. Application fees for continuing care retirement communities, and other health care models that include regulated and unregulated components, shall apply only to those components subject to regulation under this Act. All fees and fines collected under the provisions of this Act shall be deposited into the Illinois Health Facilities Planning Fund to be used for the expenses of administering this Act.

(2.1) Publish the following reports on the State Board website:

(A) An annual accounting, aggregated by category and with names of parties redacted, of fees, fines, and other revenue collected as well as expenses incurred, in the administration of this Act.

(B) An annual report, with names of the parties redacted, that summarizes all settlement agreements entered into with the State Board that resolve an alleged instance of noncompliance with State Board requirements under this Act.

(C) A monthly report that includes the status of applications and recommendations regarding updates to the standard, criteria, or the health plan as appropriate.

(D) Board reports showing the degree to which an application conforms to the review standards, a summation of relevant public testimony, and any additional information that staff wants to communicate.

(3) Coordinate with other State agencies having responsibilities affecting health care facilities, including ~~the Center for Comprehensive Health Planning and those of~~ licensure and cost reporting agencies.

(Source: P.A. 98-1086, eff. 8-26-14.)

(20 ILCS 3960/12.3)

(Section scheduled to be repealed on December 31, 2019)

Sec. 12.3. Revision of criteria, standards, and rules. At least every 2 years, the State Board shall review, revise, and update the criteria, standards, and rules used to evaluate applications for permit. ~~To the extent practicable, the criteria, standards, and rules shall be based on objective criteria using the inventory and recommendations of the Comprehensive Health Plan for guidance.~~ The Board may appoint temporary advisory committees made up of experts with professional competence in the subject matter of the proposed standards or criteria to assist in the development of revisions to standards and criteria. In particular, the review of the

criteria, standards, and rules shall consider:

(1) Whether the criteria and standards reflect current industry standards and anticipated trends.

(2) Whether the criteria and standards can be reduced or eliminated.

(3) Whether criteria and standards can be developed to authorize the construction of unfinished space for future use when the ultimate need for such space can be reasonably projected.

(4) Whether the criteria and standards take into account issues related to population growth and changing demographics in a community.

(5) Whether facility-defined service and planning areas should be recognized.

(6) Whether categories of service that are subject to review should be re-evaluated, including provisions related to structural, functional, and operational differences between long-term care facilities and acute care facilities and that allow routine changes of ownership, facility sales, and closure requests to be processed on a more timely basis.

(Source: P.A. 96-31, eff. 6-30-09.)

(20 ILCS 3960/14.1)

Sec. 14.1. Denial of permit; other sanctions.

(a) The State Board may deny an application for a permit or

may revoke or take other action as permitted by this Act with regard to a permit as the State Board deems appropriate, including the imposition of fines as set forth in this Section, for any one or a combination of the following:

(1) The acquisition of major medical equipment without a permit or in violation of the terms of a permit.

(2) The establishment, construction, modification, or change of ownership of a health care facility without a permit or exemption or in violation of the terms of a permit.

(3) The violation of any provision of this Act or any rule adopted under this Act.

(4) The failure, by any person subject to this Act, to provide information requested by the State Board or Agency within 30 days after a formal written request for the information.

(5) The failure to pay any fine imposed under this Section within 30 days of its imposition.

(a-5) For facilities licensed under the ID/DD Community Care Act, no permit shall be denied on the basis of prior operator history, other than for actions specified under item (2), (4), or (5) of Section 3-117 of the ID/DD Community Care Act. For facilities licensed under the MC/DD Act, no permit shall be denied on the basis of prior operator history, other than for actions specified under item (2), (4), or (5) of Section 3-117 of the MC/DD Act. For facilities licensed under

the Specialized Mental Health Rehabilitation Act of 2013, no permit shall be denied on the basis of prior operator history, other than for actions specified under subsections (a) and (b) ~~item (2), (4), or (5)~~ of Section 4-109 ~~3-117~~ of the Specialized Mental Health Rehabilitation Act of 2013. For facilities licensed under the Nursing Home Care Act, no permit shall be denied on the basis of prior operator history, other than for: (i) actions specified under item (2), (3), (4), (5), or (6) of Section 3-117 of the Nursing Home Care Act; (ii) actions specified under item (a)(6) of Section 3-119 of the Nursing Home Care Act; or (iii) actions within the preceding 5 years constituting a substantial and repeated failure to comply with the Nursing Home Care Act or the rules and regulations adopted by the Department under that Act. The State Board shall not deny a permit on account of any action described in this subsection (a-5) without also considering all such actions in the light of all relevant information available to the State Board, including whether the permit is sought to substantially comply with a mandatory or voluntary plan of correction associated with any action described in this subsection (a-5).

(b) Persons shall be subject to fines as follows:

(1) A permit holder who fails to comply with the requirements of maintaining a valid permit shall be fined an amount not to exceed 1% of the approved permit amount plus an additional 1% of the approved permit amount for each 30-day period, or fraction thereof, that the violation

continues.

(2) A permit holder who alters the scope of an approved project or whose project costs exceed the allowable permit amount without first obtaining approval from the State Board shall be fined an amount not to exceed the sum of (i) the lesser of $25,000 or 2% of the approved permit amount and (ii) in those cases where the approved permit amount is exceeded by more than $1,000,000, an additional $20,000 for each $1,000,000, or fraction thereof, in excess of the approved permit amount.

(2.5) A permit holder who fails to comply with the post-permit and reporting requirements set forth in Sections ~~Section~~ 5 and 8.5 shall be fined an amount not to exceed $10,000 plus an additional $10,000 for each 30-day period, or fraction thereof, that the violation continues. This fine shall continue to accrue until the date that (i) the post-permit requirements are met and the post-permit or post-exemption reports are received by the State Board or (ii) the matter is referred by the State Board to the State Board's legal counsel. The accrued fine is not waived by the permit holder submitting the required information and reports. Prior to any fine beginning to accrue, the Board shall notify, in writing, a permit holder of the due date for the post-permit and reporting requirements no later than 30 days before the due date for the requirements. This paragraph (2.5) takes effect 6 months after August 27, 2012

(the effective date of Public Act 97-1115).

(3) A person who acquires major medical equipment or who establishes a category of service without first obtaining a permit or exemption, as the case may be, shall be fined an amount not to exceed $10,000 for each such acquisition or category of service established plus an additional $10,000 for each 30-day period, or fraction thereof, that the violation continues.

(4) A person who constructs, modifies, establishes, or changes ownership of a health care facility without first obtaining a permit or exemption shall be fined an amount not to exceed $25,000 plus an additional $25,000 for each 30-day period, or fraction thereof, that the violation continues.

(5) A person who discontinues a health care facility or a category of service without first obtaining a permit or exemption shall be fined an amount not to exceed $10,000 plus an additional $10,000 for each 30-day period, or fraction thereof, that the violation continues. For purposes of this subparagraph (5), facilities licensed under the Nursing Home Care Act, the ID/DD Community Care Act, or the MC/DD Act, with the exceptions of facilities operated by a county or Illinois Veterans Homes, are exempt from this permit requirement. However, facilities licensed under the Nursing Home Care Act, the ID/DD Community Care Act, or the MC/DD Act must comply with Section 3-423 of the

Nursing Home Care Act, Section 3-423 of the ID/DD Community Care Act, or Section 3-423 of the MC/DD Act and must provide the Board and the Department of Human Services with 30 days' written notice of their intent to close. Facilities licensed under the ID/DD Community Care Act or the MC/DD Act also must provide the Board and the Department of Human Services with 30 days' written notice of their intent to reduce the number of beds for a facility.

(6) A person subject to this Act who fails to provide information requested by the State Board or Agency within 30 days of a formal written request shall be fined an amount not to exceed $1,000 plus an additional $1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or Agency.

(b-5) The State Board may accept in-kind services instead of or in combination with the imposition of a fine. This authorization is limited to cases where the non-compliant individual or entity has waived the right to an administrative hearing or opportunity to appear before the Board regarding the non-compliant matter.

(c) Before imposing any fine authorized under this Section, the State Board shall afford the person or permit holder, as the case may be, an appearance before the State Board and an opportunity for a hearing before a hearing officer appointed by the State Board. The hearing shall be conducted in accordance

with Section 10. Requests for an appearance before the State Board must be made within 30 days after receiving notice that a fine will be imposed.

(d) All fines collected under this Act shall be transmitted to the State Treasurer, who shall deposit them into the Illinois Health Facilities Planning Fund.

(e) Fines imposed under this Section shall continue to accrue until: (i) the date that the matter is referred by the State Board to the Board's legal counsel; or (ii) the date that the health care facility becomes compliant with the Act, whichever is earlier.

(Source: P.A. 98-463, eff. 8-16-13; 99-114, eff. 7-23-15; 99-180, eff. 7-29-15; revised 10-14-15.)

(20 ILCS 3960/19.5)

(Section scheduled to be repealed on December 31, 2019 and as provided internally)

Sec. 19.5. Audit. Twenty-four months after the last member of the 9-member Board is appointed, as required under this amendatory Act of the 96th General Assembly, and 36 months thereafter, the Auditor General shall commence a performance audit of the ~~Center for Comprehensive Health Planning,~~ State Board~~,~~ and the Certificate of Need processes to determine:

(1) (blank); ~~whether progress is being made to develop a Comprehensive Health Plan and whether resources are sufficient to meet the goals of the Center for~~

~~Comprehensive Health Planning;~~

(2) whether changes to the Certificate of Need processes are being implemented effectively, as well as their impact, if any, on access to safety net services; and

(3) whether fines and settlements are fair, consistent, and in proportion to the degree of violations.

The Auditor General must report on the results of the audit to the General Assembly.

This Section is repealed when the Auditor General files his or her report with the General Assembly.

(Source: P.A. 96-31, eff. 6-30-09.)

(20 ILCS 2310/2310-217 rep.)

Section 15. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by repealing Section 2310-217.".