HB4982

LRB09915971RPS40288b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB4982

by Rep. David Harris

SYNOPSIS AS INTRODUCED:

See Index

Repeals the Illinois Health Facilities Planning Act and abolishes the Health Facilities and Services Review Board. Amends various other Acts to eliminate references to the Board, the Act, and certificates of need. Amends the Health Care Worker Self-Referral Act to transfer the Board's functions under that Act to the Department of Public Health. Amends the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. Provides that the Department (instead of the Board) may require facility questionnaires to be completed annually for health care facilities licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, or the End Stage Renal Disease Facility Act. Contains provisions concerning the content of the facility questionnaires. Effective immediately.

LRB099 15971 RPS 40288 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning State agencies.

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

Section 5. The Open Meetings Act is amended by changing Section 1.02 as follows:

(5 ILCS 120/1.02) (from Ch. 102, par. 41.02)

Sec. 1.02. For the purposes of this Act:

"Meeting" means any gathering, whether in person or by video or audio conference, telephone call, electronic means (such as, without limitation, electronic mail, electronic chat, and instant messaging), or other means of contemporaneous interactive communication, of a majority of a quorum of the members of a public body held for the purpose of discussing public business or, for a 5-member public body, a quorum of the members of a public body held for the purpose of discussing public business.

Accordingly, for a 5-member public body, 3 members of the body constitute a quorum and the affirmative vote of 3 members is necessary to adopt any motion, resolution, or ordinance, unless a greater number is otherwise required.

"Public body" includes all legislative, executive, administrative or advisory bodies of the State, counties, townships, cities, villages, incorporated towns, school

districts and all other municipal corporations, boards, bureaus, committees or commissions of this State, and any subsidiary bodies of any of the foregoing including but not limited to committees and subcommittees which are supported in whole or in part by tax revenue, or which expend tax revenue, except the General Assembly and committees or commissions thereof. "Public body" includes tourism boards and convention or civic center boards located in counties that are contiguous to the Mississippi River with populations of more than 250,000 but less than 300,000. ~~"Public body" includes the Health Facilities and Services Review Board.~~ "Public body" does not include a child death review team or the Illinois Child Death Review Teams Executive Council established under the Child Death Review Team Act, an ethics commission acting under the State Officials and Employees Ethics Act, a regional youth advisory board or the Statewide Youth Advisory Board established under the Department of Children and Family Services Statewide Youth Advisory Board Act, or the Illinois Independent Tax Tribunal.

(Source: P.A. 97-1129, eff. 8-28-12; 98-806, eff. 1-1-15.)

Section 10. The State Officials and Employees Ethics Act is amended by changing Section 5-50 as follows:

(5 ILCS 430/5-50)

Sec. 5-50. Ex parte communications; special government

agents.

(a) This Section applies to ex parte communications made to any agency listed in subsection (e).

(b) "Ex parte communication" means any written or oral communication by any person that imparts or requests material information or makes a material argument regarding potential action concerning regulatory, quasi-adjudicatory, investment, or licensing matters pending before or under consideration by the agency. "Ex parte communication" does not include the following: (i) statements by a person publicly made in a public forum; (ii) statements regarding matters of procedure and practice, such as format, the number of copies required, the manner of filing, and the status of a matter; and (iii) statements made by a State employee of the agency to the agency head or other employees of that agency.

(b-5) An ex parte communication received by an agency, agency head, or other agency employee from an interested party or his or her official representative or attorney shall promptly be memorialized and made a part of the record.

(c) An ex parte communication received by any agency, agency head, or other agency employee, other than an ex parte communication described in subsection (b-5), shall immediately be reported to that agency's ethics officer by the recipient of the communication and by any other employee of that agency who responds to the communication. The ethics officer shall require that the ex parte communication be promptly made a part of the

record. The ethics officer shall promptly file the ex parte communication with the Executive Ethics Commission, including all written communications, all written responses to the communications, and a memorandum prepared by the ethics officer stating the nature and substance of all oral communications, the identity and job title of the person to whom each communication was made, all responses made, the identity and job title of the person making each response, the identity of each person from whom the written or oral ex parte communication was received, the individual or entity represented by that person, any action the person requested or recommended, and any other pertinent information. The disclosure shall also contain the date of any ex parte communication.

(d) "Interested party" means a person or entity whose rights, privileges, or interests are the subject of or are directly affected by a regulatory, quasi-adjudicatory, investment, or licensing matter.

(e) This Section applies to the following agencies:

Executive Ethics Commission

Illinois Commerce Commission

Educational Labor Relations Board

State Board of Elections

Illinois Gaming Board

~~Health Facilities and Services Review Board~~

Illinois Workers' Compensation Commission

Illinois Labor Relations Board
Illinois Liquor Control Commission
Pollution Control Board
Property Tax Appeal Board
Illinois Racing Board
Illinois Purchased Care Review Board
Department of State Police Merit Board
Motor Vehicle Review Board
Prisoner Review Board
Civil Service Commission
Personnel Review Board for the Treasurer
Merit Commission for the Secretary of State
Merit Commission for the Office of the Comptroller
Court of Claims
Board of Review of the Department of Employment Security
Department of Insurance
Department of Professional Regulation and licensing boards under the Department
Department of Public Health and licensing boards under the Department
Office of Banks and Real Estate and licensing boards under the Office
State Employees Retirement System Board of Trustees
Judges Retirement System Board of Trustees
General Assembly Retirement System Board of Trustees
Illinois Board of Investment

State Universities Retirement System Board of Trustees

Teachers Retirement System Officers Board of Trustees

(f) Any person who fails to (i) report an ex parte communication to an ethics officer, (ii) make information part of the record, or (iii) make a filing with the Executive Ethics Commission as required by this Section or as required by Section 5-165 of the Illinois Administrative Procedure Act violates this Act.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09.)

Section 15. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by changing Sections 2310-217, 2310-685, and 2310-640 and by adding Section 2310-639 as follows:

(20 ILCS 2310/2310-217)

Sec. 2310-217. Center for Comprehensive Health Planning.

(a) The Center for Comprehensive Health Planning ("Center") is hereby created to promote the distribution of health care services and improve the healthcare delivery system in Illinois by establishing a statewide Comprehensive Health Plan ~~and ensuring a predictable, transparent, and efficient Certificate of Need process under the Illinois Health Facilities Planning Act~~. The objectives of the Comprehensive Health Plan include: to assess existing community resources and determine health care needs; to support safety net services for

uninsured and underinsured residents; to promote adequate financing for health care services; and to recognize and respond to changes in community health care needs, including public health emergencies and natural disasters. The Center shall comprehensively assess health and mental health services; assess health needs with a special focus on the identification of health disparities; identify State-level and regional needs; and make findings that identify the impact of market forces on the access to high quality services for uninsured and underinsured residents. The Center shall conduct a biennial comprehensive assessment of health resources and service needs, including, but not limited to, facilities, clinical services, and workforce; conduct needs assessments using key indicators of population health status and determinations of potential benefits that could occur with certain changes in the health care delivery system; collect and analyze relevant, objective, and accurate data, including health care utilization data; identify issues related to health care financing such as revenue streams, federal opportunities, better utilization of existing resources, development of resources, and incentives for new resource development; evaluate findings by the needs assessments; and annually report to the General Assembly and the public.

The Illinois Department of Public Health shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan, which Plan shall guide

the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State.

(b) Center for Comprehensive Health Planning.

(1) Responsibilities and duties of the Center include:

(A) (blank) ~~providing technical assistance to the Health Facilities and Services Review Board to permit that Board to apply relevant components of the Comprehensive Health Plan in its deliberations~~;

(B) attempting to identify unmet health needs and assist in any inter-agency State planning for health resource development;

(C) considering health plans and other related publications that have been developed in Illinois and nationally;

(D) establishing priorities and recommend methods for meeting identified health service, facilities, and workforce needs. Plan recommendations shall be short-term, mid-term, and long-range;

(E) conducting an analysis regarding the availability of long-term care resources throughout the State, using data and plans developed under the Illinois Older Adult Services Act, to adjust existing bed need criteria and standards ~~under the Health Facilities Planning Act~~ for changes in utilization of institutional and non-institutional care options, with

special consideration of the availability of the least-restrictive options in accordance with the needs and preferences of persons requiring long-term care; and

(F) considering and recognizing health resource development projects or information on methods by which a community may receive benefit, that are consistent with health resource needs identified through the comprehensive health planning process.

(2) A Comprehensive Health Planner shall be appointed by the Governor, with the advice and consent of the Senate, to supervise the Center and its staff for a paid 3-year term, subject to review and re-approval every 3 years. The Planner shall receive an annual salary of $120,000, or an amount set by the Compensation Review Board, whichever is greater. The Planner shall prepare a budget for review and approval by the Illinois General Assembly, which shall become part of the annual report available on the Department website.

(c) Comprehensive Health Plan.

(1) The Plan shall be developed with a 5 to 10 year range, and updated every 2 years, or annually, if needed.

(2) Components of the Plan shall include:

(A) an inventory to map the State for growth, population shifts, and utilization of available healthcare resources, using both State-level and

regionally defined areas;

(B) an evaluation of health service needs, addressing gaps in service, over-supply, and continuity of care, including an assessment of existing safety net services;

(C) an inventory of health care facility infrastructure, including regulated facilities and services, and unregulated facilities and services, as determined by the Center;

(D) recommendations on ensuring access to care, especially for safety net services, including rural and medically underserved communities; and

(E) an integration between health planning for clinical services, facilities and workforce ~~under the Illinois Health Facilities Planning Act~~ and other health planning laws and activities of the State.

(3) (Blank). ~~Components of the Plan may include recommendations that will be integrated into any relevant certificate of need review criteria, standards, and procedures.~~

(d) Within 60 days of receiving the Comprehensive Health Plan, the State Board of Health shall review and comment upon the Plan and any policy change recommendations. The first Plan shall be submitted to the State Board of Health within one year after hiring the Comprehensive Health Planner. The Plan shall be submitted to the General Assembly by the following March 1.

The Center and State Board shall hold public hearings on the Plan and its updates. The Center shall permit the public to request the Plan to be updated more frequently to address emerging population and demographic trends.

(e) Current comprehensive health planning data and information about Center funding shall be available to the public on the Department website.

(f) The Department shall submit to a performance audit of the Center by the Auditor General in order to assess 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.

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

(20 ILCS 2310/2310-639 new)

Sec. 2310-639. Facility questionnaires. The Department may require facility questionnaires to be completed annually for health care facilities licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, or the End Stage Renal Disease Facility Act. For health care facilities licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013, these reports may include, but are not limited to, the identification of specialty services provided by the facility to patients,

residents, and the community at large. Annual reports for facilities licensed under the ID/DD Community Care Act and facilities licensed under the MC/DD Act may be different from the annual reports required of other health care facilities and may be specific to those facilities licensed under the ID/DD Community Care Act or the MC/DD Act. The Department shall consult with associations representing facilities licensed under the ID/DD Community Care Act and associations representing facilities licensed under the MC/DD Act when developing the information requested in these annual reports. For health care facilities that contain long-term care beds, the reports may also include the number of staffed long-term care beds, physical capacity for long-term care beds at the facility, and long-term care beds available for immediate occupancy. For purposes of this Section, "long-term care beds" means beds (i) licensed under the Nursing Home Care Act, (ii) licensed under the ID/DD Community Care Act, (iii) licensed under the MC/DD Act, (iv) licensed under the Hospital Licensing Act, or (v) licensed under the Specialized Mental Health Rehabilitation Act of 2013 and certified as skilled nursing or nursing facility beds under Medicaid or Medicare.

(20 ILCS 2310/2310-640)

Sec. 2310-640. Hospital Capital Investment Program.

(a) Subject to appropriation, the Department shall establish and administer a program to award capital grants to

Illinois hospitals licensed under the Hospital Licensing Act. Grants awarded under this program shall only be used to fund capital projects to improve or renovate the hospital's facility or to improve, replace or acquire the hospital's equipment or technology. Such projects may include, but are not limited to, projects to satisfy any building code, safety standard or life safety code; projects to maintain, improve, renovate, expand or construct buildings or structures; projects to maintain, establish or improve health information technology; or projects to maintain or improve patient safety, quality of care or access to care.

The Department shall establish rules necessary to implement the Hospital Capital Investment Program, including application standards, requirements for the distribution and obligation of grant funds, accounting for the use of the funds, reporting the status of funded projects, and standards for monitoring compliance with standards. In awarding grants under this Section, the Department shall consider criteria that include but are not limited to: the financial requirements of the project and the extent to which the grant makes it possible to implement the project; the proposed project's likely benefit in terms of patient safety or quality of care; and the proposed project's likely benefit in terms of maintaining or improving access to care.

The Department shall approve a hospital's eligibility for a hospital capital investment grant pursuant to the standards

established by this Section. The Department shall determine eligible project costs, including but not limited to the use of funds for the acquisition, development, construction, reconstruction, rehabilitation, improvement, architectural planning, engineering, and installation of capital facilities consisting of buildings, structures, technology and durable equipment for hospital purposes. No portion of a hospital capital investment grant awarded by the Department may be used by a hospital to pay for any on-going operational costs, pay outstanding debt, or be allocated to an endowment or other invested fund.

~~Nothing in this Section shall exempt nor relieve any hospital receiving a grant under this Section from any requirement of the Illinois Health Facilities Planning Act.~~

(b) Safety Net Hospital Grants. The Department shall make capital grants to hospitals eligible for safety net hospital grants under this subsection. The total amount of grants to any individual hospital shall be no less than $2,500,000 and no more than $7,000,000. The total amount of grants to hospitals under this subsection shall not exceed $100,000,000. Hospitals that satisfy one of the following criteria shall be eligible to apply for safety net hospital grants:

(1) Any general acute care hospital located in a county of over 3,000,000 inhabitants that has a Medicaid inpatient utilization rate for the rate year beginning on October 1, 2008 greater than 43%, that is not affiliated with a

hospital system that owns or operates more than 3 hospitals, and that has more than 13,500 Medicaid inpatient days.

(2) Any general acute care hospital that is located in a county of more than 3,000,000 inhabitants and has a Medicaid inpatient utilization rate for the rate year beginning on October 1, 2008 greater than 55% and has authorized beds for the obstetric-gynecology category of service as reported in the 2008 Annual Hospital Bed Report, issued by the Illinois Department of Public Health.

(3) Any hospital that is defined in 89 Illinois Administrative Code Section 149.50(c)(3)(A) and that has less than 20,000 Medicaid inpatient days.

(4) Any general acute care hospital that is located in a county of less than 3,000,000 inhabitants and has a Medicaid inpatient utilization rate for the rate year beginning on October 1, 2008 greater than 64%.

(5) Any general acute care hospital that is located in a county of over 3,000,000 inhabitants and a city of less than 1,000,000 inhabitants, that has a Medicaid inpatient utilization rate for the rate year beginning on October 1, 2008 greater than 22%, that has more than 12,000 Medicaid inpatient days, and that has a case mix index greater than 0.71.

(c) Community Hospital Grants. The Department shall make a one-time capital grant to any public or not-for-profit

hospitals located in counties of less than 3,000,000 inhabitants that are not otherwise eligible for a grant under subsection (b) of this Section and that have a Medicaid inpatient utilization rate for the rate year beginning on October 1, 2008 of at least 10%. The total amount of grants under this subsection shall not exceed $50,000,000. This grant shall be the sum of the following payments:

(1) For each acute care hospital, a base payment of:

(i) $170,000 if it is located in an urban area; or

(ii) $340,000 if it is located in a rural area.

(2) A payment equal to the product of $45 multiplied by total Medicaid inpatient days for each hospital.

(d) Annual report. The Department of Public Health shall prepare and submit to the Governor and the General Assembly an annual report by January 1 of each year regarding its administration of the Hospital Capital Investment Program, including an overview of the program and information about the specific purpose and amount of each grant and the status of funded projects. ~~The report shall include information as to whether each project is subject to and authorized under the Illinois Health Facilities Planning Act, if applicable.~~

(e) Definitions. As used in this Section, the following terms shall be defined as follows:

"General acute care hospital" shall have the same meaning as general acute care hospital in Section 5A-12.2 of the Illinois Public Aid Code.

"Hospital" shall have the same meaning as defined in Section 3 of the Hospital Licensing Act, but in no event shall it include a hospital owned or operated by a State agency, a State university, or a county with a population of 3,000,000 or more.

"Medicaid inpatient day" shall have the same meaning as defined in Section 5A-12.2(n) of the Illinois Public Aid Code.

"Medicaid inpatient utilization rate" shall have the same meaning as provided in Title 89, Chapter I, subchapter d, Part 148, Section 148.120 of the Illinois Administrative Code.

"Rural" shall have the same meaning as provided in Title 89, Chapter I, subchapter d, Part 148, Section 148.25(g)(3) of the Illinois Administrative Code.

"Urban" shall have the same meaning as provided in Title 89, Chapter I, subchapter d, Part 148, Section 148.25(g)(4) of the Illinois Administrative Code.

(Source: P.A. 96-37, eff. 7-13-09; 96-1000, eff. 7-2-10.)

(20 ILCS 2310/2310-685)

Sec. 2310-685. Health care facility; policy to encourage participation in capital projects.

(a) A health care facility shall develop a policy to encourage the participation of minority-owned, women-owned, veteran-owned, and small business enterprises in capital projects undertaken by the health care facility.

(b) A health care system may develop a system-wide policy

in order to comply with the requirement of subsection (a) of this Section.

(c) The policy required under this Section must be developed no later than 6 months after January 1, 2016 (the effective date of Public Act 99-315) ~~this amendatory Act of the 99th General Assembly~~.

(d) This Section does not apply to health care facilities with 100 or fewer beds, health care facilities located in a county with a total census population of less than 3,000,000, or health care facilities owned or operated by a unit of local government or the State or federal government.

(e) For the purpose of this Section, "health care facility" means: ~~has the same meaning as set forth in the Illinois Health Facilities Planning Act.~~

(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.

(4) Skilled and intermediate care facilities licensed under the ID/DD Community Care Act or the MC/DD Act.

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

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

(7) Kidney disease treatment centers, including a free-standing hemodialysis unit required to be licensed under the End Stage Renal Disease Facility Act.

(A) This Section 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 Section 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.

(8) 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.

(9) 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.

(10) 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.

For the purposes of this Section, "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 Section 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 Section 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 Section 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.

(Source: P.A. 99-315, eff. 1-1-16; revised 9-28-15.)

(20 ILCS 3960/Act rep.)

Section 20. The Illinois Health Facilities Planning Act is repealed.

(20 ILCS 4050/15 rep.)

Section 25. The Hospital Basic Services Preservation Act is amended by repealing Section 15.

Section 30. The Illinois State Auditing Act is amended by changing Section 3-1 as follows:

(30 ILCS 5/3-1) (from Ch. 15, par. 303-1)

Sec. 3-1. Jurisdiction of Auditor General. The Auditor General has jurisdiction over all State agencies to make post audits and investigations authorized by or under this Act or the Constitution.

The Auditor General has jurisdiction over local government agencies and private agencies only:

(a) to make such post audits authorized by or under this Act as are necessary and incidental to a post audit of a State agency or of a program administered by a State agency involving public funds of the State, but this jurisdiction does not include any authority to review local governmental agencies in the obligation, receipt, expenditure or use of public funds of the State that are granted without limitation or condition imposed by law, other than the general limitation that such funds be used for public purposes;

(b) to make investigations authorized by or under this Act or the Constitution; and

(c) to make audits of the records of local government

agencies to verify actual costs of state-mandated programs when directed to do so by the Legislative Audit Commission at the request of the State Board of Appeals under the State Mandates Act.

In addition to the foregoing, the Auditor General may conduct an audit of the Metropolitan Pier and Exposition Authority, the Regional Transportation Authority, the Suburban Bus Division, the Commuter Rail Division and the Chicago Transit Authority and any other subsidized carrier when authorized by the Legislative Audit Commission. Such audit may be a financial, management or program audit, or any combination thereof.

The audit shall determine whether they are operating in accordance with all applicable laws and regulations. Subject to the limitations of this Act, the Legislative Audit Commission may by resolution specify additional determinations to be included in the scope of the audit.

In addition to the foregoing, the Auditor General must also conduct a financial audit of the Illinois Sports Facilities Authority's expenditures of public funds in connection with the reconstruction, renovation, remodeling, extension, or improvement of all or substantially all of any existing "facility", as that term is defined in the Illinois Sports Facilities Authority Act.

The Auditor General may also conduct an audit, when authorized by the Legislative Audit Commission, of any hospital

which receives 10% or more of its gross revenues from payments from the State of Illinois, Department of Healthcare and Family Services (formerly Department of Public Aid), Medical Assistance Program.

The Auditor General is authorized to conduct financial and compliance audits of the Illinois Distance Learning Foundation and the Illinois Conservation Foundation.

As soon as practical after the effective date of this amendatory Act of 1995, the Auditor General shall conduct a compliance and management audit of the City of Chicago and any other entity with regard to the operation of Chicago O'Hare International Airport, Chicago Midway Airport and Merrill C. Meigs Field. The audit shall include, but not be limited to, an examination of revenues, expenses, and transfers of funds; purchasing and contracting policies and practices; staffing levels; and hiring practices and procedures. When completed, the audit required by this paragraph shall be distributed in accordance with Section 3-14.

The Auditor General shall conduct a financial and compliance and program audit of distributions from the Municipal Economic Development Fund during the immediately preceding calendar year pursuant to Section 8-403.1 of the Public Utilities Act at no cost to the city, village, or incorporated town that received the distributions.

~~The Auditor General must conduct an audit of the Health Facilities and Services Review Board pursuant to Section 19.5~~

~~of the Illinois Health Facilities Planning Act.~~

The Auditor General of the State of Illinois shall annually conduct or cause to be conducted a financial and compliance audit of the books and records of any county water commission organized pursuant to the Water Commission Act of 1985 and shall file a copy of the report of that audit with the Governor and the Legislative Audit Commission. The filed audit shall be open to the public for inspection. The cost of the audit shall be charged to the county water commission in accordance with Section 6z-27 of the State Finance Act. The county water commission shall make available to the Auditor General its books and records and any other documentation, whether in the possession of its trustees or other parties, necessary to conduct the audit required. These audit requirements apply only through July 1, 2007.

The Auditor General must conduct audits of the Rend Lake Conservancy District as provided in Section 25.5 of the River Conservancy Districts Act.

The Auditor General must conduct financial audits of the Southeastern Illinois Economic Development Authority as provided in Section 70 of the Southeastern Illinois Economic Development Authority Act.

The Auditor General shall conduct a compliance audit in accordance with subsections (d) and (f) of Section 30 of the Innovation Development and Economy Act.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09;

96-939, eff. 6-24-10.)

(30 ILCS 105/5.213 rep.) (from Ch. 127, par. 141.213)

Section 35. The State Finance Act is amended by repealing Section 5.213.

Section 40. The Hospital District Law is amended by changing Section 15 as follows:

(70 ILCS 910/15) (from Ch. 23, par. 1265)

Sec. 15. A Hospital District shall constitute a municipal corporation and body politic separate and apart from any other municipality, the State of Illinois or any other public or governmental agency and shall have and exercise the following governmental powers, and all other powers incidental, necessary, convenient, or desirable to carry out and effectuate such express powers.

1. To establish and maintain a hospital and hospital facilities within or outside its corporate limits, and to construct, acquire, develop, expand, extend and improve any such hospital or hospital facility. If a Hospital District utilizes its authority to levy a tax pursuant to Section 20 of this Act for the purpose of establishing and maintaining hospitals or hospital facilities, such District shall be prohibited from establishing and maintaining hospitals or hospital facilities located outside of its district unless so

authorized by referendum. To approve the provision of any service and to approve any contract or other arrangement not prohibited by a hospital licensed under the Hospital Licensing Act, incorporated under the General Not-For-Profit Corporation Act, and exempt from taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code.

2. To acquire land in fee simple, rights in land and easements upon, over or across land and leasehold interests in land and tangible and intangible personal property used or useful for the location, establishment, maintenance, development, expansion, extension or improvement of any such hospital or hospital facility. Such acquisition may be by dedication, purchase, gift, agreement, lease, use or adverse possession or by condemnation.

3. To operate, maintain and manage such hospital and hospital facility, and to make and enter into contracts for the use, operation or management of and to provide rules and regulations for the operation, management or use of such hospital or hospital facility.

Such contracts may include the lease by the District of all or any portion of its facilities to a not-for-profit corporation organized by the District's board of directors. The rent to be paid pursuant to any such lease shall be in an amount deemed appropriate by the board of directors. Any of the remaining assets which are not the subject of such a lease may be conveyed and transferred to the not-for-profit corporation

organized by the District's board of directors provided that the not-for-profit corporation agrees to discharge or assume such debts, liabilities, and obligations of the District as determined to be appropriate by the District's board of directors.

4. To fix, charge and collect reasonable fees and compensation for the use or occupancy of such hospital or any part thereof, or any hospital facility, and for nursing care, medicine, attendance, or other services furnished by such hospital or hospital facilities, according to the rules and regulations prescribed by the board from time to time.

5. To borrow money and to issue general obligation bonds, revenue bonds, notes, certificates, or other evidences of indebtedness for the purpose of accomplishing any of its corporate purposes, subject to compliance with any conditions or limitations set forth in this Act ~~or the Health Facilities Planning Act~~ or otherwise provided by the constitution of the State of Illinois and to execute, deliver, and perform mortgages and security agreements to secure such borrowing.

6. To employ or enter into contracts for the employment of any person, firm, or corporation, and for professional services, necessary or desirable for the accomplishment of the corporate objects of the District or the proper administration, management, protection or control of its property.

7. To maintain such hospital for the benefit of the inhabitants of the area comprising the District who are sick,

injured, or maimed regardless of race, creed, religion, sex, national origin or color, and to adopt such reasonable rules and regulations as may be necessary to render the use of the hospital of the greatest benefit to the greatest number; to exclude from the use of the hospital all persons who wilfully disregard any of the rules and regulations so established; to extend the privileges and use of the hospital to persons residing outside the area of the District upon such terms and conditions as the board of directors prescribes by its rules and regulations.

8. To police its property and to exercise police powers in respect thereto or in respect to the enforcement of any rule or regulation provided by the ordinances of the District and to employ and commission police officers and other qualified persons to enforce the same.

The use of any such hospital or hospital facility of a District shall be subject to the reasonable regulation and control of the District and upon such reasonable terms and conditions as shall be established by its board of directors.

A regulatory ordinance of a District adopted under any provision of this Section may provide for a suspension or revocation of any rights or privileges within the control of the District for a violation of any such regulatory ordinance.

Nothing in this Section or in other provisions of this Act shall be construed to authorize the District or board to establish or enforce any regulation or rule in respect to

hospitalization or in the operation or maintenance of such hospital or any hospital facilities within its jurisdiction which is in conflict with any federal or state law or regulation applicable to the same subject matter.

9. To provide for the benefit of its employees group life, health, accident, hospital and medical insurance, or any combination of such types of insurance, and to further provide for its employees by the establishment of a pension or retirement plan or system; to effectuate the establishment of any such insurance program or pension or retirement plan or system, a Hospital District may make, enter into or subscribe to agreements, contracts, policies or plans with private insurance companies. Such insurance may include provisions for employees who rely on treatment by spiritual means alone through prayer for healing in accord with the tenets and practice of a well-recognized religious denomination. The board of directors of a Hospital District may provide for payment by the District of a portion of the premium or charge for such insurance or for a pension or retirement plan for employees with the employee paying the balance of such premium or charge. If the board of directors of a Hospital District undertakes a plan pursuant to which the Hospital District pays a portion of such premium or charge, the board shall provide for the withholding and deducting from the compensation of such employees as consent to joining such insurance program or pension or retirement plan or system, the balance of the

premium or charge for such insurance or plan or system.

If the board of directors of a Hospital District does not provide for a program or plan pursuant to which such District pays a portion of the premium or charge for any group insurance program or pension or retirement plan or system, the board may provide for the withholding and deducting from the compensation of such employees as consent thereto the premium or charge for any group life, health, accident, hospital and medical insurance or for any pension or retirement plan or system.

A Hospital District deducting from the compensation of its employees for any group insurance program or pension or retirement plan or system, pursuant to this Section, may agree to receive and may receive reimbursement from the insurance company for the cost of withholding and transferring such amount to the company.

10. Except as provided in Section 15.3, to sell at public auction or by sealed bid and convey any real estate held by the District which the board of directors, by ordinance adopted by at least 2/3rds of the members of the board then holding office, has determined to be no longer necessary or useful to, or for the best interests of, the District.

An ordinance directing the sale of real estate shall include the legal description of the real estate, its present use, a statement that the property is no longer necessary or useful to, or for the best interests of, the District, the terms and conditions of the sale, whether the sale is to be at

public auction or sealed bid, and the date, time, and place the property is to be sold at auction or sealed bids opened.

Before making a sale by virtue of the ordinance, the board of directors shall cause notice of the proposal to sell to be published once each week for 3 successive weeks in a newspaper published, or, if none is published, having a general circulation, in the district, the first publication to be not less than 30 days before the day provided in the notice for the public sale or opening of bids for the real estate.

The notice of the proposal to sell shall include the same information included in the ordinance directing the sale and shall advertise for bids therefor. A sale of property by public auction shall be held at the property to be sold at a time and date determined by the board of directors. The board of directors may accept the high bid or any other bid determined to be in the best interests of the district by a vote of 2/3rds of the board then holding office, but by a majority vote of those holding office, they may reject any and all bids.

The chairman and secretary of the board of directors shall execute all documents necessary for the conveyance of such real property sold pursuant to the foregoing authority.

11. To establish and administer a program of loans for postsecondary students pursuing degrees in accredited public health-related educational programs at public institutions of higher education. If a student is awarded a loan, the individual shall agree to accept employment within the hospital

district upon graduation from the public institution of higher education. For the purposes of this Act, "public institutions of higher education" means the University of Illinois; Southern Illinois University; Chicago State University; Eastern Illinois University; Governors State University; Illinois State University; Northeastern Illinois University; Northern Illinois University; Western Illinois University; the public community colleges of the State; and any other public colleges, universities or community colleges now or hereafter established or authorized by the General Assembly. The district's board of directors shall by resolution provide for eligibility requirements, award criteria, terms of financing, duration of employment accepted within the district and such other aspects of the loan program as its establishment and administration may necessitate.

12. To establish and maintain congregate housing units; to acquire land in fee simple and leasehold interests in land for the location, establishment, maintenance, and development of those housing units; to borrow funds and give debt instruments, real estate mortgages, and security interests in personal property, contract rights, and general intangibles; and to enter into any contract required for participation in any federal or State programs.

(Source: P.A. 92-534, eff. 5-14-02; 92-611, eff. 7-3-02.)

Section 45. The Alternative Health Care Delivery Act is

amended by changing Sections 20, 30, and 36.5 as follows:

(210 ILCS 3/20)

Sec. 20. Board responsibilities. The State Board of Health shall have the responsibilities set forth in this Section.

(a) The Board shall investigate new health care delivery models and recommend to the Governor and the General Assembly, through the Department, those models that should be authorized as alternative health care models for which demonstration programs should be initiated. In its deliberations, the Board shall use the following criteria:

(1) The feasibility of operating the model in Illinois, based on a review of the experience in other states including the impact on health professionals of other health care programs or facilities.

(2) The potential of the model to meet an unmet need.

(3) The potential of the model to reduce health care costs to consumers, costs to third party payors, and aggregate costs to the public.

(4) The potential of the model to maintain or improve the standards of health care delivery in some measurable fashion.

(5) The potential of the model to provide increased choices or access for patients.

(b) The Board shall evaluate and make recommendations to the Governor and the General Assembly, through the Department,

regarding alternative health care model demonstration programs established under this Act, at the midpoint and end of the period of operation of the demonstration programs. The report shall include, at a minimum, the following:

(1) Whether the alternative health care models improved access to health care for their service populations in the State.

(2) The quality of care provided by the alternative health care models as may be evidenced by health outcomes, surveillance reports, and administrative actions taken by the Department.

(3) The cost and cost effectiveness to the public, third-party payors, and government of the alternative health care models, including the impact of pilot programs on aggregate health care costs in the area. In addition to any other information collected by the Board under this Section, the Board shall collect from postsurgical recovery care centers uniform billing data substantially the same as specified in Section 4-2(e) of the Illinois Health Finance Reform Act. To facilitate its evaluation of that data, the Board shall forward a copy of the data to the Illinois Health Care Cost Containment Council. All patient identifiers shall be removed from the data before it is submitted to the Board or Council.

(4) The impact of the alternative health care models on the health care system in that area, including changing

patterns of patient demand and utilization, financial viability, and feasibility of operation of service in inpatient and alternative models in the area.

(5) The implementation by alternative health care models of any special commitments made during application review ~~to the Health Facilities and Services Review Board~~.

(6) The continuation, expansion, or modification of the alternative health care models.

(c) The Board shall advise the Department on the definition and scope of alternative health care models demonstration programs.

(d) In carrying out its responsibilities under this Section, the Board shall seek the advice of other Department advisory boards or committees that may be impacted by the alternative health care model or the proposed model of health care delivery. The Board shall also seek input from other interested parties, which may include holding public hearings.

(e) The Board shall otherwise advise the Department on the administration of the Act as the Board deems appropriate.

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

(210 ILCS 3/30)

Sec. 30. Demonstration program requirements. The requirements set forth in this Section shall apply to demonstration programs.

(a) (Blank).

(a-5) (Blank). ~~There shall be no more than the total number of postsurgical recovery care centers with a certificate of need for beds as of January 1, 2008.~~

(a-10) There shall be no more than a total of 9 children's community-based health care center alternative health care models in the demonstration program, which shall be located as follows:

(1) Two in the City of Chicago.

(2) One in Cook County outside the City of Chicago.

(3) A total of 2 in the area comprised of DuPage, Kane, Lake, McHenry, and Will counties.

(4) A total of 2 in municipalities with a population of 50,000 or more and not located in the areas described in paragraphs (1), (2), or (3).

(5) A total of 2 in rural areas, as defined by the ~~Health Facilities and Services Review~~ Board.

No more than one children's community-based health care center owned and operated by a licensed skilled pediatric facility shall be located in each of the areas designated in this subsection (a-10).

(a-15) There shall be 5 authorized community-based residential rehabilitation center alternative health care models in the demonstration program.

(a-20) There shall be an authorized Alzheimer's disease management center alternative health care model in the demonstration program. The Alzheimer's disease management

center shall be located in Will County, owned by a not-for-profit entity, and endorsed by a resolution approved by the county board before the effective date of this amendatory Act of the 91st General Assembly.

(a-25) There shall be no more than 10 birth center alternative health care models in the demonstration program, located as follows:

(1) Four in the area comprising Cook, DuPage, Kane, Lake, McHenry, and Will counties, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(2) Three in municipalities with a population of 50,000 or more not located in the area described in paragraph (1) of this subsection, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(3) Three in rural areas, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

The first 3 birth centers authorized to operate by the Department shall be located in or predominantly serve the residents of a health professional shortage area as determined by the United States Department of Health and Human Services. There shall be no more than 2 birth centers authorized to operate in any single health planning area for obstetric services ~~as determined under the Illinois Health Facilities~~

~~Planning Act~~. If a birth center is located outside of a health professional shortage area, (i) the birth center shall be located in a health planning area with a demonstrated need for obstetrical service beds, as determined by the ~~Health Facilities and Services Review~~ Board or (ii) there must be a reduction in the existing number of obstetrical service beds in the planning area so that the establishment of the birth center does not result in an increase in the total number of obstetrical service beds in the health planning area.

(b) (Blank). ~~Alternative health care models, other than a model authorized under subsection (a-10) or (a-20), shall obtain a certificate of need from the Health Facilities and Services Review Board under the Illinois Health Facilities Planning Act before receiving a license by the Department. If, after obtaining its initial certificate of need, an alternative health care delivery model that is a community based residential rehabilitation center seeks to increase the bed capacity of that center, it must obtain a certificate of need from the Health Facilities and Services Review Board before increasing the bed capacity. Alternative health care models in medically underserved areas shall receive priority in obtaining a certificate of need.~~

(c) An alternative health care model license shall be issued for a period of one year and shall be annually renewed if the facility or program is in substantial compliance with the Department's rules adopted under this Act. A licensed

alternative health care model that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual renewals unless and until a different licensure program for that type of health care model is established by legislation, except that a postsurgical recovery care center meeting the following requirements may apply within 3 years after August 25, 2009 (the effective date of Public Act 96-669) ~~for a Certificate of Need permit~~ to operate as a hospital:

(1) (Blank). ~~The postsurgical recovery care center shall apply to the Health Facilities and Services Review Board for a Certificate of Need permit to discontinue the postsurgical recovery care center and to establish a hospital.~~

(2) The ~~If the~~ postsurgical recovery care center ~~obtains a Certificate of Need permit to operate as a hospital, it~~ shall apply for licensure as a hospital under the Hospital Licensing Act and shall meet all statutory and regulatory requirements of a hospital.

(3) After obtaining licensure as a hospital, any license as an ambulatory surgical treatment center and any license as a postsurgical recovery care center shall be null and void.

(4) The former postsurgical recovery care center that receives a hospital license must seek and use its best efforts to maintain certification under Titles XVIII and

XIX of the federal Social Security Act.

The Department may issue a provisional license to any alternative health care model that does not substantially comply with the provisions of this Act and the rules adopted under this Act if (i) the Department finds that the alternative health care model has undertaken changes and corrections which upon completion will render the alternative health care model in substantial compliance with this Act and rules and (ii) the health and safety of the patients of the alternative health care model will be protected during the period for which the provisional license is issued. The Department shall advise the licensee of the conditions under which the provisional license is issued, including the manner in which the alternative health care model fails to comply with the provisions of this Act and rules, and the time within which the changes and corrections necessary for the alternative health care model to substantially comply with this Act and rules shall be completed.

(d) Alternative health care models shall seek certification under Titles XVIII and XIX of the federal Social Security Act. In addition, alternative health care models shall provide charitable care consistent with that provided by comparable health care providers in the geographic area.

(d-5) (Blank).

(e) Alternative health care models shall, to the extent possible, link and integrate their services with nearby health

care facilities.

(f) Each alternative health care model shall implement a quality assurance program with measurable benefits and at reasonable cost.

(Source: P.A. 98-629, eff. 1-1-15; 98-756, eff. 7-16-14; 99-78, eff. 7-20-15.)

Section 50. The Assisted Living and Shared Housing Act is amended by changing Sections 10, 145, and 155 as follows:

(210 ILCS 9/10)

Sec. 10. Definitions. For purposes of this Act:

"Activities of daily living" means eating, dressing, bathing, toileting, transferring, or personal hygiene.

"Assisted living establishment" or "establishment" means a home, building, residence, or any other place where sleeping accommodations are provided for at least 3 unrelated adults, at least 80% of whom are 55 years of age or older and where the following are provided consistent with the purposes of this Act:

(1) services consistent with a social model that is based on the premise that the resident's unit in assisted living and shared housing is his or her own home;

(2) community-based residential care for persons who need assistance with activities of daily living, including personal, supportive, and intermittent health-related

services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident;

(3) mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment, with the consent of the resident or resident's representative; and

(4) a physical environment that is a homelike setting that includes the following and such other elements as established by the Department: individual living units each of which shall accommodate small kitchen appliances and contain private bathing, washing, and toilet facilities, or private washing and toilet facilities with a common bathing room readily accessible to each resident. Units shall be maintained for single occupancy except in cases in which 2 residents choose to share a unit. Sufficient common space shall exist to permit individual and group activities.

"Assisted living establishment" or "establishment" does not mean any of the following:

(1) A home, institution, or similar place operated by the federal government or the State of Illinois.

(2) A long term care facility licensed under the Nursing Home Care Act, a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013, a facility licensed under the ID/DD Community Care Act, or a facility licensed under the MC/DD Act. However, a facility

licensed under any of those Acts may convert distinct parts of the facility to assisted living. ~~If the facility elects to do so, the facility shall retain the Certificate of Need for its nursing and sheltered care beds that were converted.~~

(3) A hospital, sanitarium, or other institution, the principal activity or business of which is the diagnosis, care, and treatment of human illness and that is required to be licensed under the Hospital Licensing Act.

(4) A facility for child care as defined in the Child Care Act of 1969.

(5) A community living facility as defined in the Community Living Facilities Licensing Act.

(6) A nursing home or sanitarium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer in accordance with the creed or tenants of a well-recognized church or religious denomination.

(7) A facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act.

(8) A supportive residence licensed under the Supportive Residences Licensing Act.

(9) The portion of a life care facility as defined in the Life Care Facilities Act not licensed as an assisted

living establishment under this Act; a life care facility may apply under this Act to convert sections of the community to assisted living.

(10) A free-standing hospice facility licensed under the Hospice Program Licensing Act.

(11) A shared housing establishment.

(12) A supportive living facility as described in Section 5-5.01a of the Illinois Public Aid Code.

"Department" means the Department of Public Health.

"Director" means the Director of Public Health.

"Emergency situation" means imminent danger of death or serious physical harm to a resident of an establishment.

"License" means any of the following types of licenses issued to an applicant or licensee by the Department:

(1) "Probationary license" means a license issued to an applicant or licensee that has not held a license under this Act prior to its application or pursuant to a license transfer in accordance with Section 50 of this Act.

(2) "Regular license" means a license issued by the Department to an applicant or licensee that is in substantial compliance with this Act and any rules promulgated under this Act.

"Licensee" means a person, agency, association, corporation, partnership, or organization that has been issued a license to operate an assisted living or shared housing establishment.

"Licensed health care professional" means a registered professional nurse, an advanced practice nurse, a physician assistant, and a licensed practical nurse.

"Mandatory services" include the following:

(1) 3 meals per day available to the residents prepared by the establishment or an outside contractor;

(2) housekeeping services including, but not limited to, vacuuming, dusting, and cleaning the resident's unit;

(3) personal laundry and linen services available to the residents provided or arranged for by the establishment;

(4) security provided 24 hours each day including, but not limited to, locked entrances or building or contract security personnel;

(5) an emergency communication response system, which is a procedure in place 24 hours each day by which a resident can notify building management, an emergency response vendor, or others able to respond to his or her need for assistance; and

(6) assistance with activities of daily living as required by each resident.

"Negotiated risk" is the process by which a resident, or his or her representative, may formally negotiate with providers what risks each are willing and unwilling to assume in service provision and the resident's living environment. The provider assures that the resident and the resident's

representative, if any, are informed of the risks of these decisions and of the potential consequences of assuming these risks.

"Owner" means the individual, partnership, corporation, association, or other person who owns an assisted living or shared housing establishment. In the event an assisted living or shared housing establishment is operated by a person who leases or manages the physical plant, which is owned by another person, "owner" means the person who operates the assisted living or shared housing establishment, except that if the person who owns the physical plant is an affiliate of the person who operates the assisted living or shared housing establishment and has significant control over the day to day operations of the assisted living or shared housing establishment, the person who owns the physical plant shall incur jointly and severally with the owner all liabilities imposed on an owner under this Act.

"Physician" means a person licensed under the Medical Practice Act of 1987 to practice medicine in all of its branches.

"Resident" means a person residing in an assisted living or shared housing establishment.

"Resident's representative" means a person, other than the owner, agent, or employee of an establishment or of the health care provider unless related to the resident, designated in writing by a resident to be his or her representative. This

designation may be accomplished through the Illinois Power of Attorney Act, pursuant to the guardianship process under the Probate Act of 1975, or pursuant to an executed designation of representative form specified by the Department.

"Self" means the individual or the individual's designated representative.

"Shared housing establishment" or "establishment" means a publicly or privately operated free-standing residence for 16 or fewer persons, at least 80% of whom are 55 years of age or older and who are unrelated to the owners and one manager of the residence, where the following are provided:

(1) services consistent with a social model that is based on the premise that the resident's unit is his or her own home;

(2) community-based residential care for persons who need assistance with activities of daily living, including housing and personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident; and

(3) mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment, with the consent of the resident or the resident's representative.

"Shared housing establishment" or "establishment" does not mean any of the following:

(1) A home, institution, or similar place operated by the federal government or the State of Illinois.

(2) A long term care facility licensed under the Nursing Home Care Act, a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013, a facility licensed under the ID/DD Community Care Act, or a facility licensed under the MC/DD Act. A facility licensed under any of those Acts may, however, convert sections of the facility to assisted living. ~~If the facility elects to do so, the facility shall retain the Certificate of Need for its nursing beds that were converted.~~

(3) A hospital, sanitarium, or other institution, the principal activity or business of which is the diagnosis, care, and treatment of human illness and that is required to be licensed under the Hospital Licensing Act.

(4) A facility for child care as defined in the Child Care Act of 1969.

(5) A community living facility as defined in the Community Living Facilities Licensing Act.

(6) A nursing home or sanitarium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer in accordance with the creed or tenants of a well-recognized church or religious denomination.

(7) A facility licensed by the Department of Human Services as a community-integrated living arrangement as

defined in the Community-Integrated Living Arrangements Licensure and Certification Act.

(8) A supportive residence licensed under the Supportive Residences Licensing Act.

(9) A life care facility as defined in the Life Care Facilities Act; a life care facility may apply under this Act to convert sections of the community to assisted living.

(10) A free-standing hospice facility licensed under the Hospice Program Licensing Act.

(11) An assisted living establishment.

(12) A supportive living facility as described in Section 5-5.01a of the Illinois Public Aid Code.

"Total assistance" means that staff or another individual performs the entire activity of daily living without participation by the resident.

(Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

(210 ILCS 9/145)

Sec. 145. Conversion of facilities. Entities licensed as facilities 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 may elect to convert to a license under this Act. Any facility that chooses to convert, in whole or in part, shall follow the requirements in the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of

2013, the ID/DD Community Care Act, or the MC/DD Act, as applicable, and rules promulgated under those Acts regarding voluntary closure and notice to residents. ~~Any conversion of existing beds 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 to licensure under this Act is exempt from review by the Health Facilities and Services Review Board.~~

(Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

(210 ILCS 9/155)

Sec. 155. Application of Act. An establishment licensed under this Act shall obtain and maintain all other licenses, permits, certificates, and other governmental approvals required of it~~, except that a licensed assisted living or shared housing establishment is exempt from the provisions of the Illinois Health Facilities Planning Act~~. An establishment licensed under this Act shall comply with the requirements of all local, State, federal, and other applicable laws, rules, and ordinances and the National Fire Protection Association's Life Safety Code.

(Source: P.A. 91-656, eff. 1-1-01.)

Section 55. The Life Care Facilities Act is amended by changing Sections 2 and 7 as follows:

(210 ILCS 40/2) (from Ch. 111 1/2, par. 4160-2)

Sec. 2. As used in this Act, unless the context otherwise requires:

(a) "Department" means the Department of Public Health.

(b) "Director" means the Director of the Department.

(c) "Life care contract" means a contract to provide to a person for the duration of such person's life or for a term in excess of one year, nursing services, medical services or personal care services, in addition to maintenance services for such person in a facility, conditioned upon the transfer of an entrance fee to the provider of such services in addition to or in lieu of the payment of regular periodic charges for the care and services involved.

(d) "Provider" means a person who provides services pursuant to a life care contract.

(e) "Resident" means a person who enters into a life care contract with a provider, or who is designated in a life care contract to be a person provided with maintenance and nursing, medical or personal care services.

(f) "Facility" means a place or places in which a provider undertakes to provide a resident with nursing services, medical services or personal care services, in addition to maintenance services for a term in excess of one year or for life pursuant to a life care contract. The term also means a place or places in which a provider undertakes to provide such services to a non-resident.

(g) "Living unit" means an apartment, room or other area within a facility set aside for the exclusive use of one or more identified residents.

(h) "Entrance fee" means an initial or deferred transfer to a provider of a sum of money or property, made or promised to be made by a person entering into a life care contract, which assures a resident of services pursuant to a life care contract.

(i) "Permit" means a written authorization to enter into life care contracts issued by the Department to a provider.

(j) "Medical services" means those services pertaining to medical or dental care that are performed in behalf of patients at the direction of a physician licensed under the Medical Practice Act of 1987 or a dentist licensed under the Illinois Dental Practice Act by such physicians or dentists, or by a registered or licensed practical nurse as defined in the Nurse Practice Act or by other professional and technical personnel.

(k) "Nursing services" means those services pertaining to the curative, restorative and preventive aspects of nursing care that are performed at the direction of a physician licensed under the Medical Practice Act of 1987 by or under the supervision of a registered or licensed practical nurse as defined in the Nurse Practice Act.

(l) "Personal care services" means assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the

physical and mental well-being of an individual, who is incapable of maintaining a private, independent residence or who is incapable of managing his person whether or not a guardian has been appointed for such individual.

(m) "Maintenance services" means food, shelter and laundry services.

(n) (Blank) ~~"Certificates of Need" means those permits issued pursuant to the Illinois Health Facilities Planning Act as now or hereafter amended~~.

(o) "Non-resident" means a person admitted to a facility who has not entered into a life care contract.

(Source: P.A. 95-639, eff. 10-5-07.)

(210 ILCS 40/7) (from Ch. 111 1/2, par. 4160-7)

Sec. 7. As a condition for the issuance of a permit pursuant to this Act, the provider shall establish and maintain on a current basis, a letter of credit or an escrow account with a bank, trust company, or other financial institution located in the State of Illinois. The letter of credit shall be in an amount and form acceptable to the Department, but in no event shall the amount exceed that applicable to the corresponding escrow agreement alternative, as described below. The terms of the escrow agreement shall meet the following provisions:

(a) Requirements for new facilities.

(1) If the entrance fee applies to a living unit which has

not previously been occupied by any resident, all entrance fee payments representing either all or any smaller portion of the total entrance fee shall be paid to the escrow agent by the resident.

(2) When the provider has sold at least 1/2 of its living units, obtained a mortgage commitment, if needed, and obtained all necessary zoning permits ~~and Certificates of Need, if required~~, the escrow agent may release a sum representing 1/5 of the resident's total entrance fee to the provider. Upon completion of the foundation of the living unit an additional 1/5 of the resident's total entrance fee may be released to the provider. When the living unit is under roof a further and additional 1/5 of the resident's total entrance fee may be released to the provider. All remaining monies, if any, shall remain in escrow until the resident's living unit is substantially completed and ready for occupancy by the resident. When the living unit is ready for occupancy the escrow agent may release the remaining escrow amount to the provider and further entrance fee payments, if any, may be paid by the resident to the provider directly. All monies released from escrow shall be used for the facility and for no other purpose.

(b) General requirements for all facilities, including new and existing facilities.

(1) At the time of resident occupancy and at all times thereafter, the escrow amount shall be in an amount which

equals or exceeds the aggregate principal and interest payments due during the next 6 months on account of any first mortgage or other long-term financing of the facility. Existing facilities shall have 2 years from the date of this Act becoming law to comply with this subsection. Upon application from a facility showing good cause, the Director may extend compliance with this subsection one additional year.

(2) Notwithstanding paragraph (1) of this subsection, the escrow monies required under paragraph (1) of this subsection may be released to the provider upon approval by the Director. The Director may attach such conditions on the release of monies as he deems fit including, but not limited to, the performance of an audit which satisfies the Director that the facility is solvent, a plan from the facility to bring the facility back in compliance with paragraph (1) of this subsection, and a repayment schedule.

(3) The principal of the escrow account may be invested with the earnings thereon payable to the provider as it accrues.

(4) If the facility ceases to operate all monies in the escrow account except the amount representing principal and interest shall be repaid by the escrow agent to the resident.

(5) Balloon payments due at conclusion of the mortgage shall not be subject to the escrow requirements of paragraph (1) this subsection.

(Source: P.A. 85-1349.)

Section 60. The Nursing Home Care Act is amended by changing Sections 3-102.2 and 3-103 as follows:

(210 ILCS 45/3-102.2)

Sec. 3-102.2. Supported congregate living arrangement demonstration. The Illinois Department may grant no more than 3 waivers from the requirements of this Act for facilities participating in the supported congregate living arrangement demonstration. A joint waiver request must be made by an applicant and the Department on Aging. If the Department on Aging does not act upon an application within 60 days, the applicant may submit a written waiver request on its own behalf. The waiver request must include a specific program plan describing the types of residents to be served and the services that will be provided in the facility. The Department shall conduct an on-site review at each facility annually or as often as necessary to ascertain compliance with the program plan. The Department may revoke the waiver if it determines that the facility is not in compliance with the program plan. Nothing in this Section prohibits the Department from conducting complaint investigations.

~~A facility granted a waiver under this Section is not subject to the Illinois Health Facilities Planning Act, unless it subsequently applies for a certificate of need to convert to a nursing facility.~~ A facility applying for conversion shall

meet the licensure ~~and certificate of need~~ requirements in effect as of the date of application, and this provision may not be waived.

(Source: P.A. 89-530, eff. 7-19-96.)

(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 $1,990. Facilities that pay a fee or assessment pursuant to Article V-C of the Illinois Public Aid Code shall be exempt from the license fee imposed under this item (2). The fee for a 2-year license shall be double the fee for the annual license. The fees collected 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. 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 of this Act, for the enforcement of this Act, for expenses related to surveyor development, and for implementation of the Abuse Prevention Review Team Act. All federal moneys received as a result of expenditures from the Fund shall be

deposited into the Fund. The Department may reduce or waive a penalty pursuant to Section 3-308 only if that action will not threaten the ability of the Department to meet the expenses required to be met by the Long Term Care Monitor/Receiver 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. 96-758, eff. 8-25-09; 96-1372, eff. 7-29-10; 96-1504, eff. 1-27-11; 96-1530, eff. 2-16-11; 97-489, eff. 1-1-12.)

Section 65. The MC/DD Act is amended by changing Section 3-103 as follows:

(210 ILCS 46/3-103)

Sec. 3-103. Application for license; financial statement. 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 $995. Facilities that pay a fee or assessment pursuant to Article V-C of the Illinois Public Aid Code shall be exempt from the license fee imposed under this item (2). The fee for a 2-year license shall be double the fee for the annual license set forth in the preceding sentence. The fees collected 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. 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 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. 99-180, eff. 7-29-15.)

Section 70. The ID/DD Community Care Act is amended by changing Section 3-103 as follows:

(210 ILCS 47/3-103)

Sec. 3-103. Application for license; financial statement. 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 $995. Facilities that pay a fee or assessment pursuant to Article V-C of the Illinois Public Aid Code shall be exempt from the license fee imposed under this item (2). The fee

for a 2-year license shall be double the fee for the annual license set forth in the preceding sentence. The fees collected 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. 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 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. 96-339, eff. 7-1-10.)

Section 75. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Section 1-101.5 as follows:

(210 ILCS 49/1-101.5)

Sec. 1-101.5. Prior law.

(a) This Act provides for licensure of long term care facilities that are federally designated as institutions for the mentally diseased on the effective date of this Act and specialize in providing services to individuals with a serious mental illness. On and after the effective date of this Act, these facilities shall be governed by this Act instead of the Nursing Home Care Act.

(b) All consent decrees that apply to facilities federally designated as institutions for the mentally diseased shall continue to apply to facilities licensed under this Act.

(c) A facility licensed under this Act may voluntarily close, and the facility may reopen in an underserved region of the State~~, if the facility receives a certificate of need from the Health Facilities and Services Review Board~~. At no time shall the total number of licensed beds under this Act exceed the total number of licensed beds existing on July 22, 2013 (the effective date of Public Act 98-104).

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14.)

Section 80. The Emergency Medical Services (EMS) Systems

Act is amended by changing Section 32.5 as follows:

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

(a) The Department shall issue an annual Freestanding Emergency Center (FEC) license to any facility that has received a permit from the Health Facilities and Services Review Board to establish a Freestanding Emergency Center by January 1, 2015, and:

(1) is located: (A) in a municipality with a population of 50,000 or fewer inhabitants; (B) within 50 miles of the hospital that owns or controls the FEC; and (C) within 50 miles of the Resource Hospital affiliated with the FEC as part of the EMS System;

(2) is wholly owned or controlled by an Associate or Resource Hospital, but is not a part of the hospital's physical plant;

(3) meets the standards for licensed FECs, adopted by rule of the Department, including, but not limited to:

(A) facility design, specification, operation, and maintenance standards;

(B) equipment standards; and

(C) the number and qualifications of emergency medical personnel and other staff, which must include at least one board certified emergency physician present at the FEC 24 hours per day.

(4) limits its participation in the EMS System strictly to receiving a limited number of BLS runs by emergency medical vehicles according to protocols developed by the Resource Hospital within the FEC's designated EMS System and approved by the Project Medical Director and the Department;

(5) provides comprehensive emergency treatment services, as defined in the rules adopted by the Department pursuant to the Hospital Licensing Act, 24 hours per day, on an outpatient basis;

(6) provides an ambulance and maintains on site ambulance services staffed with paramedics 24 hours per day;

(7) (blank);

(8) complies with all State and federal patient rights provisions, including, but not limited to, the Emergency Medical Treatment Act and the federal Emergency Medical Treatment and Active Labor Act;

(9) maintains a communications system that is fully integrated with its Resource Hospital within the FEC's designated EMS System;

(10) reports to the Department any patient transfers from the FEC to a hospital within 48 hours of the transfer plus any other data determined to be relevant by the Department;

(11) submits to the Department, on a quarterly basis,

the FEC's morbidity and mortality rates for patients treated at the FEC and other data determined to be relevant by the Department;

(12) does not describe itself or hold itself out to the general public as a full service hospital or hospital emergency department in its advertising or marketing activities;

(13) complies with any other rules adopted by the Department under this Act that relate to FECs;

(14) passes the Department's site inspection for compliance with the FEC requirements of this Act;

(15) (blank) ~~submits a copy of the permit issued by the Health Facilities and Services Review Board indicating that the facility has complied with the Illinois Health Facilities Planning Act with respect to the health services to be provided at the facility~~;

(16) submits an application for designation as an FEC in a manner and form prescribed by the Department by rule; and

(17) pays the annual license fee as determined by the Department by rule.

(a-5) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility that is located in a county that does not have a licensed general acute care hospital ~~if the facility's application for a permit from the Illinois Health Facilities Planning Board has~~

~~been deemed complete by the Department of Public Health by January 1, 2014 and~~ if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

(a-10) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility if the facility has, by January 1, 2014, filed a letter of intent to establish an FEC and if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

(a-15) Notwithstanding any other provision of this Section, the Department shall issue an annual FEC license to a facility if the facility~~:~~ (i) discontinues operation as a hospital within 180 days after the effective date of this amendatory Act of the 99th General Assembly with a Health Facilities and Services Review Board project number of E-017-15~~; (ii) has an application for a permit to establish an FEC from the Health Facilities and Services Review Board that is deemed complete by January 1, 2017;~~ and (ii) ~~(iii)~~ complies with the requirements set forth in paragraphs (1) through (17) of subsection (a) of this Section.

(b) The Department shall:

(1) annually inspect facilities of initial FEC applicants and licensed FECs, and issue annual licenses to or annually relicense FECs that satisfy the Department's licensure requirements as set forth in subsection (a);

(2) suspend, revoke, refuse to issue, or refuse to renew the license of any FEC, after notice and an opportunity for a hearing, when the Department finds that the FEC has failed to comply with the standards and requirements of the Act or rules adopted by the Department under the Act;

(3) issue an Emergency Suspension Order for any FEC when the Director or his or her designee has determined that the continued operation of the FEC poses an immediate and serious danger to the public health, safety, and welfare. An opportunity for a hearing shall be promptly initiated after an Emergency Suspension Order has been issued; and

(4) adopt rules as needed to implement this Section.

(Source: P.A. 99-490, eff. 12-4-15.)

Section 85. The Hospital Emergency Service Act is amended by changing Section 1.3 as follows:

(210 ILCS 80/1.3)

Sec. 1.3. Long-term acute care hospitals and rehabilitation hospitals. For the purpose of this Act, general acute care hospitals designated by Medicare as long-term acute care hospitals and rehabilitation hospitals are not required to provide hospital emergency services described in Section 1 of this Act. Hospitals defined in this Section may provide

hospital emergency services at their option.

Any long-term acute care hospital that opts to discontinue or otherwise not provide emergency services described in Section 1 shall:

(1) comply with all provisions of the federal Emergency Medical Treatment and Labor Act (EMTALA);

(2) comply with all provisions required under the Social Security Act;

(3) provide annual notice to communities in the hospital's service area about available emergency medical services; and

(4) make educational materials available to individuals who are present at the hospital concerning the availability of medical services within the hospital's service area.

Long-term acute care hospitals that operate standby emergency services as of January 1, 2011 may discontinue hospital emergency services by notifying the Department of Public Health. Long-term acute care hospitals that operate basic or comprehensive emergency services must notify the Department of Public Health ~~Health Facilities and Services Review Board~~ and follow the appropriate procedures.

Any rehabilitation hospital that opts to discontinue or otherwise not provide emergency services described in Section 1 shall:

(1) comply with all provisions of the federal Emergency

Medical Treatment and Active Labor Act (EMTALA);

(2) comply with all provisions required under the Social Security Act;

(3) provide annual notice to communities in the hospital's service area about available emergency medical services;

(4) make educational materials available to individuals who are present at the hospital concerning the availability of medical services within the hospital's service area;

(5) not use the term "hospital" in its name or on any signage; and

(6) notify in writing the Department ~~and the Health Facilities and Services Review Board~~ of the discontinuation.

(Source: P.A. 97-667, eff. 1-13-12; 98-683, eff. 6-30-14; 98-756, eff. 7-16-14.)

Section 90. The Hospital Licensing Act is amended by changing Sections 4.5, 4.6, 4.7, and 10.8 as follows:

(210 ILCS 85/4.5)

Sec. 4.5. Hospital with multiple locations; single license.

(a) A hospital located in a county with fewer than 3,000,000 inhabitants may apply to the Department for approval

to conduct its operations from more than one location within the county under a single license.

(b) The facilities or buildings at those locations must be owned or operated together by a single corporation or other legal entity serving as the licensee and must share:

(1) a single board of directors with responsibility for governance, including financial oversight and the authority to designate or remove the chief executive officer;

(2) a single medical staff accountable to the board of directors and governed by a single set of medical staff bylaws, rules, and regulations with responsibility for the quality of the medical services; and

(3) a single chief executive officer, accountable to the board of directors, with management responsibility.

(c) Each hospital building or facility that is located on a site geographically separate from the campus or premises of another hospital building or facility operated by the licensee must, at a minimum, individually comply with the Department's hospital licensing requirements for emergency services.

(d) The hospital shall submit to the Department a comprehensive plan in relation to the waiver or waivers requested describing the services and operations of each facility or building and how common services or operations will be coordinated between the various locations. With the exception of items required by subsection (c), the Department

is authorized to waive compliance with the hospital licensing requirements for specific buildings or facilities, provided that the hospital has documented which other building or facility under its single license provides that service or operation, and that doing so would not endanger the public's health, safety, or welfare. ~~Nothing in this Section relieves a hospital from the requirements of the Health Facilities Planning Act.~~

(Source: P.A. 89-171, eff. 7-19-95.)

(210 ILCS 85/4.6)

Sec. 4.6. Additional licensing requirements.

(a) Notwithstanding any other law or rule to the contrary, the Department may license as a hospital a building that (i) is owned or operated by a hospital licensed under this Act, (ii) is located in a municipality with a population of less than 60,000, and (iii) includes a postsurgical recovery care center licensed under the Alternative Health Care Delivery Act for a period of not less than 2 years, an ambulatory surgical treatment center licensed under the Ambulatory Surgical Treatment Center Act, and a Freestanding Emergency Center licensed under the Emergency Medical Services (EMS) Systems Act. Only the components of the building which are currently licensed shall be eligible under the provisions of this Section.

(b) Prior to issuing a license, the Department shall

inspect the facility and require the facility to meet such of the Department's rules relating to the establishment of hospitals as the Department determines are appropriate to such facility. Once the Department approves the facility and issues a hospital license, all other licenses as listed in subsection (a) above shall be null and void.

(c) Only one license may be issued under the authority of this Section. No license may be issued after 18 months after the effective date of this amendatory Act of the 91st General Assembly.

(d) Beginning on the effective date of this amendatory Act of the 96th General Assembly, each hospital building or facility that is (i) located on the campus of the licensee but on a site that is not contiguous, adjacent, or otherwise attached to the main hospital building of the campus of the licensee, (ii) operated by the licensee, and (iii) provides inpatient services to patients at this building or facility shall, at a minimum, individually comply with the Department's hospital licensing requirements for emergency services. The hospital shall submit to the Department a comprehensive plan describing the services and operations of each facility or building and how common services or operations will be coordinated between the various locations. The Department shall review the plan and may authorize a waiver granting an exemption for compliance with the hospital licensing requirements for specific buildings or facilities, including

requirements for emergency services, provided that the hospital has documented which other building or facility under its single license provides that service or operation, and that doing so would not endanger the public's health, safety, or welfare. ~~Nothing in this Section relieves a hospital from the requirements of the Illinois Health Facilities Planning Act.~~

(Source: P.A. 96-1515, eff. 2-4-11.)

(210 ILCS 85/4.7)

Sec. 4.7. Additional licensing requirements.

(a) A hospital located in a county with fewer than 325,000 inhabitants may apply to the Department for approval to conduct its operations from more than one location within the county under a single license at a separate building or facility already licensed as a hospital. The operations shall be limited to psychiatric services. The host hospital shall house the licensee. The licensee's application shall be supported by information that its operations at the host hospital will provide access to necessary services for the region that the host hospital does not provide. The services proposed by the licensee at the host hospital shall not consist of emergency services.

(b) The portion of the facilities or buildings operated by the licensee at the host hospital shall be leased in part and operated by a single corporation or other legal entity serving as the licensee and shall have a single:

(1) board of directors with the responsibility for governance, including financial oversight and authority to designate or remove the chief executive officer;

(2) medical staff accountable to the board of directors of the licensee and governed by a single set of medical staff bylaws and associated rules and regulation of the licensee, with responsibility for the quality of the medical services provided by the licensee at the host hospital side; and

(3) chief executive officer, accountable to the board of directors of the licensee, with management responsibility for the licensee's operations at the host hospital site.

The host hospital and licensee shall be jointly responsible for hospital licensing requirements relating to design and construction, engineering and maintenance of the physical plan, waste disposal, and fire safety.

(c) The licensee and host hospital shall notify the public and patients through general signage and written notification provided upon admission that services are provided at the host hospital site by 2 separately licensed hospitals. The signage shall specify which services are provided by the host hospital or the licensee or both.

(d) One emergency department shall serve the host hospital. Patients shall be notified that emergency services are provided by the host hospital. Those patients that require admission

from the emergency department to a service that is operated by the licensee shall be admitted according to the Emergency Medical Treatment and Active Labor Act regulations and transferred to the licensee. The admission, registration, and consent form documents shall be specific to the licensee.

(e) The licensee and host hospital shall submit to the Department a comprehensive plan describing the services and operations of each facility or building and between the licensee and host hospital, and how common services or operations will be coordinated between the various locations. ~~Nothing in this Section relieves a hospital from the requirements in the Illinois Health Facilities Planning Act.~~

(Source: P.A. 96-1505, eff. 1-27-11.)

(210 ILCS 85/10.8)

Sec. 10.8. Requirements for employment of physicians.

(a) Physician employment by hospitals and hospital affiliates. Employing entities may employ physicians to practice medicine in all of its branches provided that the following requirements are met:

(1) The employed physician is a member of the medical staff of either the hospital or hospital affiliate. If a hospital affiliate decides to have a medical staff, its medical staff shall be organized in accordance with written bylaws where the affiliate medical staff is responsible for making recommendations to the governing body of the

affiliate regarding all quality assurance activities and safeguarding professional autonomy. The affiliate medical staff bylaws may not be unilaterally changed by the governing body of the affiliate. Nothing in this Section requires hospital affiliates to have a medical staff.

(2) Independent physicians, who are not employed by an employing entity, periodically review the quality of the medical services provided by the employed physician to continuously improve patient care.

(3) The employing entity and the employed physician sign a statement acknowledging that the employer shall not unreasonably exercise control, direct, or interfere with the employed physician's exercise and execution of his or her professional judgment in a manner that adversely affects the employed physician's ability to provide quality care to patients. This signed statement shall take the form of a provision in the physician's employment contract or a separate signed document from the employing entity to the employed physician. This statement shall state: "As the employer of a physician, (employer's name) shall not unreasonably exercise control, direct, or interfere with the employed physician's exercise and execution of his or her professional judgment in a manner that adversely affects the employed physician's ability to provide quality care to patients."

(4) The employing entity shall establish a mutually

agreed upon independent review process with criteria under which an employed physician may seek review of the alleged violation of this Section by physicians who are not employed by the employing entity. The affiliate may arrange with the hospital medical staff to conduct these reviews. The independent physicians shall make findings and recommendations to the employing entity and the employed physician within 30 days of the conclusion of the gathering of the relevant information.

(b) Definitions. For the purpose of this Section:

"Employing entity" means a hospital licensed under the Hospital Licensing Act or a hospital affiliate.

"Employed physician" means a physician who receives an IRS W-2 form, or any successor federal income tax form, from an employing entity.

"Hospital" means a hospital licensed under the Hospital Licensing Act, except county hospitals as defined in subsection (c) of Section 15-1 of the Public Aid Code.

"Hospital affiliate" means a corporation, partnership, joint venture, limited liability company, or similar organization, other than a hospital, that is devoted primarily to the provision, management, or support of health care services and that directly or indirectly controls, is controlled by, or is under common control of the hospital. "Control" means having at least an equal or a majority ownership or membership interest. A hospital affiliate shall be

100% owned or controlled by any combination of hospitals, their parent corporations, or physicians licensed to practice medicine in all its branches in Illinois. "Hospital affiliate" does not include a health maintenance organization regulated under the Health Maintenance Organization Act.

"Physician" means an individual licensed to practice medicine in all its branches in Illinois.

"Professional judgment" means the exercise of a physician's independent clinical judgment in providing medically appropriate diagnoses, care, and treatment to a particular patient at a particular time. Situations in which an employing entity does not interfere with an employed physician's professional judgment include, without limitation, the following:

(1) practice restrictions based upon peer review of the physician's clinical practice to assess quality of care and utilization of resources in accordance with applicable bylaws;

(2) supervision of physicians by appropriately licensed medical directors, medical school faculty, department chairpersons or directors, or supervising physicians;

(3) written statements of ethical or religious directives; and

(4) reasonable referral restrictions that do not, in the reasonable professional judgment of the physician,

adversely affect the health or welfare of the patient.

(c) Private enforcement. An employed physician aggrieved by a violation of this Act may seek to obtain an injunction or reinstatement of employment with the employing entity as the court may deem appropriate. Nothing in this Section limits or abrogates any common law cause of action. Nothing in this Section shall be deemed to alter the law of negligence.

(d) Department enforcement. The Department may enforce the provisions of this Section, but nothing in this Section shall require or permit the Department to license, certify, or otherwise investigate the activities of a hospital affiliate not otherwise required to be licensed by the Department.

(e) Retaliation prohibited. No employing entity shall retaliate against any employed physician for requesting a hearing or review under this Section. No action may be taken that affects the ability of a physician to practice during this review, except in circumstances where the medical staff bylaws authorize summary suspension.

(f) Physician collaboration. No employing entity shall adopt or enforce, either formally or informally, any policy, rule, regulation, or practice inconsistent with the provision of adequate collaboration, including medical direction of licensed advanced practice nurses or supervision of licensed physician assistants and delegation to other personnel under Section 54.5 of the Medical Practice Act of 1987.

(g) Physician disciplinary actions. Nothing in this

Section shall be construed to limit or prohibit the governing body of an employing entity or its medical staff, if any, from taking disciplinary actions against a physician as permitted by law.

(h) Physician review. Nothing in this Section shall be construed to prohibit a hospital or hospital affiliate from making a determination not to pay for a particular health care service or to prohibit a medical group, independent practice association, hospital medical staff, or hospital governing body from enforcing reasonable peer review or utilization review protocols or determining whether the employed physician complied with those protocols.

(i) (Blank) ~~Review. Nothing in this Section may be used or construed to establish that any activity of a hospital or hospital affiliate is subject to review under the Illinois Health Facilities Planning Act~~.

(j) Rules. The Department shall adopt any rules necessary to implement this Section.

(Source: P.A. 92-455, eff. 9-30-01.)

(225 ILCS 7/4 rep.)

Section 95. The Board and Care Home Act is amended by repealing Section 4.

Section 100. The Health Care Worker Self-Referral Act is amended by changing Sections 5, 15, 20, 30, 35, and 40 as

follows:

(225 ILCS 47/5)

Sec. 5. Legislative intent. The General Assembly recognizes that patient referrals by health care workers for health services to an entity in which the referring health care worker has an investment interest may present a potential conflict of interest. The General Assembly finds that these referral practices may limit or completely eliminate competitive alternatives in the health care market. In some instances, these referral practices may expand and improve care or may make services available which were previously unavailable. They may also provide lower cost options to patients or increase competition. Generally, referral practices are positive occurrences. However, self-referrals may result in over utilization of health services, increased overall costs of the health care systems, and may affect the quality of health care.

It is the intent of the General Assembly to provide guidance to health care workers regarding acceptable patient referrals, to prohibit patient referrals to entities providing health services in which the referring health care worker has an investment interest, and to protect the citizens of Illinois from unnecessary and costly health care expenditures.

Recognizing the need for flexibility to quickly respond to changes in the delivery of health services, to avoid results

beyond the limitations on self referral provided under this Act and to provide minimal disruption to the appropriate delivery of health care, the Department of Public Health may adopt rules ~~Health Facilities and Services Review Board shall be exclusively and solely authorized~~ to implement ~~and interpret~~ this Act ~~through adopted rules~~.

The General Assembly recognizes that changes in delivery of health care has resulted in various methods by which health care workers practice their professions. It is not the intent of the General Assembly to limit appropriate delivery of care, nor force unnecessary changes in the structures created by workers for the health and convenience of their patients.

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

(225 ILCS 47/15)

Sec. 15. Definitions. In this Act:

(a) "Department" means the Department of Public Health. ~~"Board" means the Health Facilities and Services Review Board.~~

(b) "Entity" means any individual, partnership, firm, corporation, or other business that provides health services but does not include an individual who is a health care worker who provides professional services to an individual.

(c) "Group practice" means a group of 2 or more health care workers legally organized as a partnership, professional corporation, not-for-profit corporation, faculty practice plan or a similar association in which:

(1) each health care worker who is a member or employee or an independent contractor of the group provides substantially the full range of services that the health care worker routinely provides, including consultation, diagnosis, or treatment, through the use of office space, facilities, equipment, or personnel of the group;

(2) the services of the health care workers are provided through the group, and payments received for health services are treated as receipts of the group; and

(3) the overhead expenses and the income from the practice are distributed by methods previously determined by the group.

(d) "Health care worker" means any individual licensed under the laws of this State to provide health services, including but not limited to: dentists licensed under the Illinois Dental Practice Act; dental hygienists licensed under the Illinois Dental Practice Act; nurses and advanced practice nurses licensed under the Nurse Practice Act; occupational therapists licensed under the Illinois Occupational Therapy Practice Act; optometrists licensed under the Illinois Optometric Practice Act of 1987; pharmacists licensed under the Pharmacy Practice Act; physical therapists licensed under the Illinois Physical Therapy Act; physicians licensed under the Medical Practice Act of 1987; physician assistants licensed under the Physician Assistant Practice Act of 1987; podiatric physicians licensed under the Podiatric Medical Practice Act of

1987; clinical psychologists licensed under the Clinical Psychologist Licensing Act; clinical social workers licensed under the Clinical Social Work and Social Work Practice Act; speech-language pathologists and audiologists licensed under the Illinois Speech-Language Pathology and Audiology Practice Act; or hearing instrument dispensers licensed under the Hearing Instrument Consumer Protection Act, or any of their successor Acts.

(e) "Health services" means health care procedures and services provided by or through a health care worker.

(f) "Immediate family member" means a health care worker's spouse, child, child's spouse, or a parent.

(g) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments except that investment interest for purposes of Section 20 does not include interest in a hospital licensed under the laws of the State of Illinois.

(h) "Investor" means an individual or entity directly or indirectly owning a legal or beneficial ownership or investment interest, (such as through an immediate family member, trust, or another entity related to the investor).

(i) "Office practice" includes the facility or facilities at which a health care worker, on an ongoing basis, provides or supervises the provision of professional health services to

individuals.

(j) "Referral" means any referral of a patient for health services, including, without limitation:

(1) The forwarding of a patient by one health care worker to another health care worker or to an entity outside the health care worker's office practice or group practice that provides health services.

(2) The request or establishment by a health care worker of a plan of care outside the health care worker's office practice or group practice that includes the provision of any health services.

(Source: P.A. 98-214, eff. 8-9-13.)

(225 ILCS 47/20)

Sec. 20. Prohibited referrals and claims for payment.

(a) A health care worker shall not refer a patient for health services to an entity outside the health care worker's office or group practice in which the health care worker is an investor, unless the health care worker directly provides health services within the entity and will be personally involved with the provision of care to the referred patient.

(b) Pursuant to Department ~~Board~~ determination that the following exception is applicable, a health care worker may invest in and refer to an entity, whether or not the health care worker provides direct services within said entity, if there is a demonstrated need in the community for the entity

and alternative financing is not available. For purposes of this subsection (b), "demonstrated need" in the community for the entity may exist if (1) there is no facility of reasonable quality that provides medically appropriate service, (2) use of existing facilities is onerous or creates too great a hardship for patients, (3) the entity is formed to own or lease medical equipment which replaces obsolete or otherwise inadequate equipment in or under the control of a hospital located in a federally designated health manpower shortage area, or (4) such other standards as established, by rule, by the Department ~~Board~~. "Community" shall be defined as a metropolitan area for a city, and a county for a rural area. In addition, the following provisions must be met to be exempt under this Section:

(1) Individuals who are not in a position to refer patients to an entity are given a bona fide opportunity to also invest in the entity on the same terms as those offered a referring health care worker; and

(2) No health care worker who invests shall be required or encouraged to make referrals to the entity or otherwise generate business as a condition of becoming or remaining an investor; and

(3) The entity shall market or furnish its services to referring health care worker investors and other investors on equal terms; and

(4) The entity shall not loan funds or guarantee any

loans for health care workers who are in a position to refer to an entity; and

(5) The income on the health care worker's investment shall be tied to the health care worker's equity in the facility rather than to the volume of referrals made; and

(6) Any investment contract between the entity and the health care worker shall not include any covenant or non-competition clause that prevents a health care worker from investing in other entities; and

(7) When making a referral, a health care worker must disclose his investment interest in an entity to the patient being referred to such entity. If alternative facilities are reasonably available, the health care worker must provide the patient with a list of alternative facilities. The health care worker shall inform the patient that they have the option to use an alternative facility other than one in which the health care worker has an investment interest and the patient will not be treated differently by the health care worker if the patient chooses to use another entity. This shall be applicable to all health care worker investors, including those who provide direct care or services for their patients in entities outside their office practices; and

(8) If a third party payor requests information with regard to a health care worker's investment interest, the same shall be disclosed; and

(9) The entity shall establish an internal utilization review program to ensure that investing health care workers provided appropriate or necessary utilization; and

(10) If a health care worker's financial interest in an entity is incompatible with a referred patient's interest, the health care worker shall make alternative arrangements for the patient's care.

The Department ~~Board~~ shall make such a determination for a health care worker within 90 days of a completed written request. Failure to make such a determination within the 90 day time frame shall mean that no alternative is practical based upon the facts set forth in the completed written request.

(c) It shall not be a violation of this Act for a health care worker to refer a patient for health services to a publicly traded entity in which he or she has an investment interest provided that:

(1) the entity is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated inter-dealer quotation system operated by the National Association of Securities Dealers; and

(2) the entity had, at the end of the corporation's most recent fiscal year, total net assets of at least $30,000,000 related to the furnishing of health services; and

(3) any investment interest obtained after the

effective date of this Act is traded on the exchanges listed in paragraph 1 of subsection (c) of this Section after the entity became a publicly traded corporation; and

(4) the entity markets or furnishes its services to referring health care worker investors and other health care workers on equal terms; and

(5) all stock held in such publicly traded companies, including stock held in the predecessor privately held company, shall be of one class without preferential treatment as to status or remuneration; and

(6) the entity does not loan funds or guarantee any loans for health care workers who are in a position to be referred to an entity; and

(7) the income on the health care worker's investment is tied to the health care worker's equity in the entity rather than to the volume of referrals made; and

(8) the investment interest does not exceed 1/2 of 1% of the entity's total equity.

(d) Any hospital licensed under the Hospital Licensing Act shall not discriminate against or otherwise penalize a health care worker for compliance with this Act.

(e) Any health care worker or other entity shall not enter into an arrangement or scheme seeking to make referrals to another health care worker or entity based upon the condition that the health care worker or entity will make referrals with an intent to evade the prohibitions of this Act by inducing

patient referrals which would be prohibited by this Section if the health care worker or entity made the referral directly.

(f) If compliance with the need and alternative investor criteria is not practical, the health care worker shall identify to the patient reasonably available alternative facilities. The Department ~~Board~~ shall, by rule, designate when compliance is "not practical".

(g) Health care workers may request from the Department ~~Board~~ that it render an advisory opinion that a referral to an existing or proposed entity under specified circumstances does or does not violate the provisions of this Act. The Department's ~~Board's~~ opinion shall be presumptively correct. Failure to render such an advisory opinion within 90 days of a completed written request pursuant to this Section shall create a rebuttable presumption that a referral described in the completed written request is not or will not be a violation of this Act.

(h) Notwithstanding any provision of this Act to the contrary, a health care worker may refer a patient, who is a member of a health maintenance organization "HMO" licensed in this State, for health services to an entity, outside the health care worker's office or group practice, in which the health care worker is an investor, provided that any such referral is made pursuant to a contract with the HMO. Furthermore, notwithstanding any provision of this Act to the contrary, a health care worker may refer an enrollee of a

"managed care community network", as defined in subsection (b) of Section 5-11 of the Illinois Public Aid Code, for health services to an entity, outside the health care worker's office or group practice, in which the health care worker is an investor, provided that any such referral is made pursuant to a contract with the managed care community network.

(Source: P.A. 92-370, eff. 8-15-01.)

(225 ILCS 47/30)

Sec. 30. Rulemaking. The Department ~~Health Facilities and Services Review Board~~ shall exclusively and solely implement the provisions of this Act pursuant to rules adopted in accordance with the Illinois Administrative Procedure Act concerning, but not limited to:

(a) Standards and procedures for the administration of this Act.

(b) Procedures and criteria for exceptions from the prohibitions set forth in Section 20.

(c) Procedures and criteria for determining practical compliance with the needs and alternative investor criteria in Section 20.

(d) Procedures and criteria for determining when a written request for an opinion set forth in Section 20 is complete.

(e) Procedures and criteria for advising health care workers of the applicability of this Act to practices pursuant to written requests.

(f) Any rules of the Health Facilities and Services Review Board adopted under the Health Care Worker Self-Referral Act that are in full force on the effective date of this amendatory Act of the 99th General Assembly shall become the rules of the Department. This amendatory Act of the 99th General Assembly does not affect the legality of any such rules in the Illinois Administrative Code.

Any proposed rules filed with the Secretary of State by the Health Facilities and Services Review Board that are pending in the rulemaking process on the effective date of this amendatory Act of the 99th General Assembly and pertain to the Health Care Worker Self-Referral Act shall be deemed to have been filed by the Department. As soon as practicable hereafter, the Department shall revise and clarify the rules transferred to it under this amendatory Act of the 99th General Assembly to reflect the reorganization of powers, duties, rights, and responsibilities affected by this amendatory Act, using the procedures for recodification of rules available under the Illinois Administrative Procedure Act, except that existing title, part, and section numbering for the affected rules may be retained.

The Department may propose and adopt under the Illinois Administrative Procedure Act such other rules of the Health Facilities and Services Review Board that may be useful to its administration of the Health Care Worker Self-Referral Act.

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

(225 ILCS 47/35)

Sec. 35. Administrative Procedure Act; application. The Illinois Administrative Procedure Act is hereby expressly adopted and incorporated herein and shall apply to the Department ~~Board~~ as if all of the provisions of such Act were included in this Act; except that in case of a conflict between the Illinois Administrative Procedure Act and this Act the provisions of this Act shall control.

(Source: P.A. 87-1207.)

(225 ILCS 47/40)

Sec. 40. Review under Administrative Review Law. Any person who is adversely affected by a final decision of the Department ~~Board~~ may have such decision judicially reviewed. The provisions of the Administrative Review Law and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Department ~~Board~~. The term "administrative decisions" is as defined in Section 3-101 of the Code of Civil Procedure.

(Source: P.A. 87-1207.)

Section 105. The Nurse Agency Licensing Act is amended by changing Section 3 as follows:

(225 ILCS 510/3) (from Ch. 111, par. 953)

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

(a) "Certified nurse aide" means an individual certified as defined in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, or Section 3-206 of the MC/DD Act, as now or hereafter amended.

(b) "Department" means the Department of Labor.

(c) "Director" means the Director of Labor.

(d) "Health care facility" means and includes the following facilities and organizations: ~~is defined as in Section 3 of the Illinois Health Facilities Planning Act, as now or hereafter amended.~~

(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;

(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.

(e) "Licensee" means any nursing agency which is properly licensed under this Act.

(f) "Nurse" means a registered nurse or a licensed practical nurse as defined in the Nurse Practice Act.

(g) "Nurse agency" means any individual, firm, corporation, partnership or other legal entity that employs, assigns or refers nurses or certified nurse aides to a health care facility for a fee. The term "nurse agency" includes nurses registries. The term "nurse agency" does not include services provided by home health agencies licensed and operated under the Home Health, Home Services, and Home Nursing Agency Licensing Act or a licensed or certified individual who provides his or her own services as a regular employee of a health care facility, nor does it apply to a health care facility's organizing nonsalaried employees to provide services only in that facility.

(Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

Section 110. The Illinois Public Aid Code is amended by changing Sections 5-5.01a and 5-5.02 as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program. The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is either a free-standing facility or a distinct physical and operational entity within a nursing facility. A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial

participation by the Centers for Medicare and Medicaid Services.

The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act ~~and the Illinois Health Facilities Planning Act~~.

(Source: P.A. 98-651, eff. 6-16-14.)

(305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to Hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

(1) For inpatient hospital services rendered, or if applicable, for inpatient hospital discharges occurring,

on or after July 1, 1992 and on or before September 30, 1992, the Illinois Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the inpatient payment rate calculated for each hospital, as of June 30, 1992. For purposes of this paragraph, "reimbursement methodologies" means all reimbursement methodologies that pertain to the provision of inpatient hospital services, including, but not limited to, any adjustments for disproportionate share, targeted access, critical care access and uncompensated care, as defined by the Illinois Department on June 30, 1992.

(2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

(3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as

defined by the Illinois Department on June 30, 1992, the adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

(b) Inpatient payments. For inpatient services provided on or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the Illinois Department's prospective reimbursement methodology, or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended, except that for rate year 2015 and after a hospital described in Section 1923(b)(1)(B) of the federal Social Security Act and qualified for the payments described in subsection (c) of this Section for rate year 2014 provided

the hospital continues to meet the description in Section 1923(b)(1)(B) in the current determination year; or

(2) Illinois hospitals that have a Medicaid inpatient utilization rate which is at least one-half a standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department; or

(3) Illinois hospitals that on July 1, 1991 had a Medicaid inpatient utilization rate, as defined in paragraph (h) of this Section, that was at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department and which were located in a planning area with one-third or fewer excess beds ~~as determined by the Health Facilities and Services Review Board~~, and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area; or

(4) Illinois hospitals that:

(A) have a Medicaid inpatient utilization rate that is at least equal to the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department; and

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in

Illinois receiving Medicaid payments from the Department for obstetrical services; or

(5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children if either (i) the facility devoted exclusively to caring for children is separately licensed as a hospital by a municipality prior to February 28, 2013 or (ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days as defined by the Department in rulemaking.

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the hospital's Medicaid inpatient utilization rate as follows:

(1) hospitals with a Medicaid inpatient utilization rate below the mean shall receive a per day adjustment payment equal to $25;

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization

rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

(3) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (5) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of

Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

(e) The inpatient adjustment payments described in paragraphs (c) and (d) shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12 month period for which data are available, or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate. The sum of the inpatient adjustment payments under paragraphs (c) and (d) to a hospital, other than a county hospital (as defined in subsection (c) of Section 15-1 of this Code) or a hospital organized under the University of Illinois Hospital Act, however, shall not exceed $275 per day; that limit shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph

(b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

(g) County hospital inpatient adjustment payments. For county hospitals, as defined in subsection (c) of Section 15-1 of this Code, there shall be an adjustment payment as determined by rules issued by the Illinois Department.

(h) For the purposes of this Section the following terms shall be defined as follows:

(1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

(3) "Medicaid obstetrical inpatient utilization rate" means the ratio of Medicaid obstetrical inpatient days to total Medicaid inpatient days for all Illinois hospitals receiving Medicaid payments from the Illinois Department.

(i) Inpatient adjustment payment limit. In order to meet the limits of Public Law 102-234 and Public Law 103-66, the

Illinois Department shall by rule adjust disproportionate share adjustment payments.

(j) University of Illinois Hospital inpatient adjustment payments. For hospitals organized under the University of Illinois Hospital Act, there shall be an adjustment payment as determined by rules adopted by the Illinois Department.

(k) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(l) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

Section 115. The Older Adult Services Act is amended by changing Sections 20, 25, and 30 as follows:

(320 ILCS 42/20)

Sec. 20. Priority service areas; service expansion.

(a) The requirements of this Section are subject to the availability of funding.

(b) The Department, subject to appropriation, shall expand older adult services that promote independence and permit older adults to remain in their own homes and communities. Priority

shall be given to both the expansion of services and the development of new services in priority service areas.

(c) Inventory of services. The Department shall develop and maintain an inventory and assessment of (i) the types and quantities of public older adult services and, to the extent possible, privately provided older adult services, including the unduplicated count, location, and characteristics of individuals served by each facility, program, or service and (ii) the resources supporting those services, no later than July 1, 2012. The Department shall investigate the cost of compliance with this provision and report these findings to the appropriation committees of both chambers assigned to hear the agency's budget no later than January 1, 2012. If the Department determines that compliance is cost prohibitive, it shall recommend action in the alternative to achieve the intent of this Section and identify priority service areas for the purpose of directing the allocation of new resources and the reallocation of existing resources to areas of greatest need.

(d) Priority service areas. The Departments shall assess the current and projected need for older adult services throughout the State, analyze the results of the inventory, and identify priority service areas, which shall serve as the basis for a priority service plan to be filed with the Governor and the General Assembly no later than July 1, 2006, and every 5 years thereafter. The January 1, 2012 report required under subsection (c) of this Section shall serve as compliance with

the July 1, 2011 reporting requirement.

(e) Moneys appropriated by the General Assembly for the purpose of this Section, receipts from transfers, donations, grants, fees, or taxes that may accrue from any public or private sources to the Department for the purpose of providing services and care to older adults, and savings attributable to the nursing home conversion program as calculated in subsection (h) shall be deposited into the Department on Aging State Projects Fund. Interest earned by those moneys in the Fund shall be credited to the Fund.

(f) Moneys described in subsection (e) from the Department on Aging State Projects Fund shall be used for older adult services, regardless of where the older adult receives the service, with priority given to both the expansion of services and the development of new services in priority service areas. Fundable services shall include:

(1) Housing, health services, and supportive services:

(A) adult day care;

(B) adult day care for persons with Alzheimer's disease and related disorders;

(C) activities of daily living;

(D) care-related supplies and equipment;

(E) case management;

(F) community reintegration;

(G) companion;

(H) congregate meals;

(I) counseling and education;

(J) elder abuse prevention and intervention;

(K) emergency response and monitoring;

(L) environmental modifications;

(M) family caregiver support;

(N) financial;

(O) home delivered meals;

(P) homemaker;

(Q) home health;

(R) hospice;

(S) laundry;

(T) long-term care ombudsman;

(U) medication reminders;

(V) money management;

(W) nutrition services;

(X) personal care;

(Y) respite care;

(Z) residential care;

(AA) senior benefits outreach;

(BB) senior centers;

(CC) 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 Program);

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

(EE) training for direct family caregivers;

(FF) transition;

(GG) transportation;

(HH) wellness and fitness programs; and

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

(2) Older Adult Services Demonstration Grants, pursuant to subsection (g) of this Section.

(g) Older Adult Services Demonstration Grants. The Department may establish a program of demonstration grants to assist in the restructuring of the delivery system for older adult services and provide funding for innovative service delivery models and system change and integration initiatives. The Department shall prescribe, by rule, the grant application process. At a minimum, every application must include:

(1) The type of grant sought;

(2) A description of the project;

(3) The objective of the project;

(4) The likelihood of the project meeting identified needs;

(5) The plan for financing, administration, and

evaluation of the project;

(6) The timetable for implementation;

(7) The roles and capabilities of responsible individuals and organizations;

(8) Documentation of collaboration with other service providers, local community government leaders, and other stakeholders, other providers, and any other stakeholders in the community;

(9) Documentation of community support for the project, including support by other service providers, local community government leaders, and other stakeholders;

(10) The total budget for the project;

(11) The financial condition of the applicant; and

(12) Any other application requirements that may be established by the Department by rule.

Each project may include provisions for a designated staff person who is responsible for the development of the project and recruitment of providers.

Projects may include, but are not limited to: adult family foster care; family adult day care; assisted living in a supervised apartment; personal services in a subsidized housing project; training for caregivers; specialized assisted living units; evening and weekend home care coverage; small incentive grants to attract new providers; money following the person; cash and counseling; managed long-term care; and

respite care projects that establish a local coordinated network of volunteer and paid respite workers, coordinate assignment of respite workers to caregivers and older adults, ensure the health and safety of the older adult, provide training for caregivers, and ensure that support groups are available in the community.

~~A demonstration project funded in whole or in part by an Older Adult Services Demonstration Grant is exempt from the requirements of the Illinois Health Facilities Planning Act. To the extent applicable, however, for the purpose of maintaining the statewide inventory authorized by the Illinois Health Facilities Planning Act, the Department shall send to the Health Facilities and Services Review Board a copy of each grant award made under this subsection (g).~~

The Department, in collaboration with the Departments of Public Health and Healthcare and Family Services, shall evaluate the effectiveness of the projects receiving grants under this Section.

(h) No later than July 1 of each year, the Department of Public Health shall provide information to the Department of Healthcare and Family Services to enable the Department of Healthcare and Family Services to annually document and verify the savings attributable to the nursing home conversion program for the previous fiscal year to estimate an annual amount of such savings that may be appropriated to the Department on Aging State Projects Fund and notify the General Assembly, the

Department on Aging, the Department of Human Services, and the Advisory Committee of the savings no later than October 1 of the same fiscal year.

(Source: P.A. 96-31, eff. 6-30-09; 97-448, eff. 8-19-11.)

(320 ILCS 42/25)

Sec. 25. Older adult services restructuring. No later than January 1, 2005, the Department shall commence the process of restructuring the older adult services delivery system. Priority shall be given to both the expansion of services and the development of new services in priority service areas. Subject to the availability of funding, the restructuring shall include, but not be limited to, the following:

(1) Planning. The Department on Aging and the Departments of Public Health and Healthcare and Family Services shall develop a plan to restructure the State's service delivery system for older adults pursuant to this Act no later than September 30, 2010. The plan shall include a schedule for the implementation of the initiatives outlined in this Act and all other initiatives identified by the participating agencies to fulfill the purposes of this Act and shall protect the rights of all older Illinoisans to services based on their health circumstances and functioning level, regardless of whether they receive their care in their homes, in a community setting, or in a residential facility. Financing for older adult services shall be based on the principle that "money follows

the individual" taking into account individual preference, but shall not jeopardize the health, safety, or level of care of nursing home residents. The plan shall also identify potential impediments to delivery system restructuring and include any known regulatory or statutory barriers.

(2) Comprehensive case management. The Department shall implement a statewide system of holistic comprehensive case management. The system shall include the identification and implementation of a universal, comprehensive assessment tool to be used statewide to determine the level of functional, cognitive, socialization, and financial needs of older adults. This tool shall be supported by an electronic intake, assessment, and care planning system linked to a central location. "Comprehensive case management" includes services and coordination such as (i) comprehensive assessment of the older adult (including the physical, functional, cognitive, psycho-social, and social needs of the individual); (ii) development and implementation of a service plan with the older adult to mobilize the formal and family resources and services identified in the assessment to meet the needs of the older adult, including coordination of the resources and services with any other plans that exist for various formal services, such as hospital discharge plans, and with the information and assistance services; (iii) coordination and monitoring of formal and family service delivery, including coordination and monitoring to ensure that services specified in the plan are

being provided; (iv) periodic reassessment and revision of the status of the older adult with the older adult or, if necessary, the older adult's designated representative; and (v) in accordance with the wishes of the older adult, advocacy on behalf of the older adult for needed services or resources.

(3) Coordinated point of entry. The Department shall implement and publicize a statewide coordinated point of entry using a uniform name, identity, logo, and toll-free number.

(4) Public web site. The Department shall develop a public web site that provides links to available services, resources, and reference materials concerning caregiving, diseases, and best practices for use by professionals, older adults, and family caregivers.

(5) Expansion of older adult services. The Department shall expand older adult services that promote independence and permit older adults to remain in their own homes and communities.

(6) Consumer-directed home and community-based services. The Department shall expand the range of service options available to permit older adults to exercise maximum choice and control over their care.

(7) Comprehensive delivery system. The Department shall expand opportunities for older adults to receive services in systems that integrate acute and chronic care.

(8) Enhanced transition and follow-up services. The Department shall implement a program of transition from one

residential setting to another and follow-up services, regardless of residential setting, pursuant to rules with respect to (i) resident eligibility, (ii) assessment of the resident's health, cognitive, social, and financial needs, (iii) development of transition plans, and (iv) the level of services that must be available before transitioning a resident from one setting to another.

(9) Family caregiver support. The Department shall develop strategies for public and private financing of services that supplement and support family caregivers.

(10) Quality standards and quality improvement. The Department shall establish a core set of uniform quality standards for all providers that focus on outcomes and take into consideration consumer choice and satisfaction, and the Department shall require each provider to implement a continuous quality improvement process to address consumer issues. The continuous quality improvement process must benchmark performance, be person-centered and data-driven, and focus on consumer satisfaction.

(11) Workforce. The Department shall develop strategies to attract and retain a qualified and stable worker pool, provide living wages and benefits, and create a work environment that is conducive to long-term employment and career development. Resources such as grants, education, and promotion of career opportunities may be used.

(12) Coordination of services. The Department shall

identify methods to better coordinate service networks to maximize resources and minimize duplication of services and ease of application.

(13) Barriers to services. The Department shall identify barriers to the provision, availability, and accessibility of services and shall implement a plan to address those barriers. The plan shall: (i) identify barriers, including but not limited to, statutory and regulatory complexity, reimbursement issues, payment issues, and labor force issues; (ii) recommend changes to State or federal laws or administrative rules or regulations; (iii) recommend application for federal waivers to improve efficiency and reduce cost and paperwork; (iv) develop innovative service delivery models; and (v) recommend application for federal or private service grants.

(14) Reimbursement and funding. The Department shall investigate and evaluate costs and payments by defining costs to implement a uniform, audited provider cost reporting system to be considered by all Departments in establishing payments. To the extent possible, multiple cost reporting mandates shall not be imposed.

(15) Medicaid nursing home cost containment and Medicare utilization. The Department of Healthcare and Family Services (formerly Department of Public Aid), in collaboration with the Department on Aging and the Department of Public Health and in consultation with the Advisory Committee, shall propose a plan to contain Medicaid nursing home costs and maximize Medicare

utilization. The plan must not impair the ability of an older adult to choose among available services. The plan shall include, but not be limited to, (i) techniques to maximize the use of the most cost-effective services without sacrificing quality and (ii) methods to identify and serve older adults in need of minimal services to remain independent, but who are likely to develop a need for more extensive services in the absence of those minimal services.

(16) Bed reduction. The Department of Public Health shall implement a nursing home conversion program to reduce the number of Medicaid-certified nursing home beds in areas with excess beds. The Department of Healthcare and Family Services shall investigate changes to the Medicaid nursing facility reimbursement system in order to reduce beds. Such changes may include, but are not limited to, incentive payments that will enable facilities to adjust to the restructuring and expansion of services required by the Older Adult Services Act, including adjustments for the voluntary closure or layaway of nursing home beds certified under Title XIX of the federal Social Security Act. Any savings shall be reallocated to fund home-based or community-based older adult services pursuant to Section 20.

(17) Financing. The Department shall investigate and evaluate financing options for older adult services and shall make recommendations in the report required by Section 15 concerning the feasibility of these financing arrangements.

These arrangements shall include, but are not limited to:

(A) private long-term care insurance coverage for older adult services;

(B) enhancement of federal long-term care financing initiatives;

(C) employer benefit programs such as medical savings accounts for long-term care;

(D) individual and family cost-sharing options;

(E) strategies to reduce reliance on government programs;

(F) fraudulent asset divestiture and financial planning prevention; and

(G) methods to supplement and support family and community caregiving.

(18) Older Adult Services Demonstration Grants. The Department shall implement a program of demonstration grants that will assist in the restructuring of the older adult services delivery system, and shall provide funding for innovative service delivery models and system change and integration initiatives pursuant to subsection (g) of Section 20.

(19) (Blank). ~~Bed need methodology update. For the purposes of determining areas with excess beds, the Departments shall provide information and assistance to the Health Facilities and Services Review Board to update the Bed Need Methodology for Long Term Care to update the assumptions used to establish the~~

~~methodology to make them consistent with modern older adult services.~~

(20) Affordable housing. The Departments shall utilize the recommendations of Illinois' Annual Comprehensive Housing Plan, as developed by the Affordable Housing Task Force through the Governor's Executive Order 2003-18, in their efforts to address the affordable housing needs of older adults.

The Older Adult Services Advisory Committee shall investigate innovative and promising practices operating as demonstration or pilot projects in Illinois and in other states. The Department on Aging shall provide the Older Adult Services Advisory Committee with a list of all demonstration or pilot projects funded by the Department on Aging, including those specified by rule, law, policy memorandum, or funding arrangement. The Committee shall work with the Department on Aging to evaluate the viability of expanding these programs into other areas of the State.

(Source: P.A. 96-31, eff. 6-30-09; 96-248, eff. 8-11-09; 96-1000, eff. 7-2-10.)

(320 ILCS 42/30)

Sec. 30. Nursing home conversion program.

(a) The Department of Public Health, in collaboration with the Department on Aging and the Department of Healthcare and Family Services, shall establish a nursing home conversion program. Start-up grants, pursuant to subsections (l) and (m)

of this Section, shall be made available to nursing homes as appropriations permit as an incentive to reduce certified beds, retrofit, and retool operations to meet new service delivery expectations and demands.

(b) Grant moneys shall be made available for capital and other costs related to: (1) the conversion of all or a part of a nursing home to an assisted living establishment or a special program or unit for persons with Alzheimer's disease or related disorders licensed under the Assisted Living and Shared Housing Act or a supportive living facility established under Section 5-5.01a of the Illinois Public Aid Code; (2) the conversion of multi-resident bedrooms in the facility into single-occupancy rooms; and (3) the development of any of the services identified in a priority service plan that can be provided by a nursing home within the confines of a nursing home or transportation services. Grantees shall be required to provide a minimum of a 20% match toward the total cost of the project.

(c) Nothing in this Act shall prohibit the co-location of services or the development of multifunctional centers under subsection (f) of Section 20, including a nursing home offering community-based services or a community provider establishing a residential facility.

(d) A certified nursing home with at least 50% of its resident population having their care paid for by the Medicaid program is eligible to apply for a grant under this Section.

(e) Any nursing home receiving a grant under this Section

shall reduce the number of certified nursing home beds by a number equal to or greater than the number of beds being converted for one or more of the permitted uses under item (1) or (2) of subsection (b). ~~The nursing home shall retain the Certificate of Need for its nursing and sheltered care beds that were converted for 15 years.~~ If the beds are reinstated by the provider or its successor in interest, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant. The Department shall establish, by rule, the bed reduction methodology for nursing homes that receive a grant pursuant to item (3) of subsection (b).

(f) Any nursing home receiving a grant under this Section shall agree that, for a minimum of 10 years after the date that the grant is awarded, a minimum of 50% of the nursing home's resident population shall have their care paid for by the Medicaid program. If the nursing home provider or its successor in interest ceases to comply with the requirement set forth in this subsection, the provider shall pay to the fund from which the grant was awarded, on an amortized basis, the amount of the grant.

(g) Before awarding grants, the Department of Public Health shall seek recommendations from the Department on Aging and the Department of Healthcare and Family Services. The Department of Public Health shall attempt to balance the distribution of grants among geographic regions, and among small and large

nursing homes. The Department of Public Health shall develop, by rule, the criteria for the award of grants based upon the following factors:

(1) the unique needs of older adults (including those with moderate and low incomes), caregivers, and providers in the geographic area of the State the grantee seeks to serve;

(2) whether the grantee proposes to provide services in a priority service area;

(3) the extent to which the conversion or transition will result in the reduction of certified nursing home beds in an area with excess beds;

(4) the compliance history of the nursing home; and

(5) any other relevant factors identified by the Department, including standards of need.

(h) A conversion funded in whole or in part by a grant under this Section must not:

(1) diminish or reduce the quality of services available to nursing home residents;

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

(3) diminish or reduce the supply and distribution of nursing home services in any community below the level of need, as defined by the Department by rule; or

(4) cause undue hardship on any person who requires

nursing home care.

(i) The Department shall prescribe, by rule, the grant application process. At a minimum, every application must include:

(1) the type of grant sought;

(2) a description of the project;

(3) the objective of the project;

(4) the likelihood of the project meeting identified needs;

(5) the plan for financing, administration, and evaluation of the project;

(6) the timetable for implementation;

(7) the roles and capabilities of responsible individuals and organizations;

(8) documentation of collaboration with other service providers, local community government leaders, and other stakeholders, other providers, and any other stakeholders in the community;

(9) documentation of community support for the project, including support by other service providers, local community government leaders, and other stakeholders;

(10) the total budget for the project;

(11) the financial condition of the applicant; and

(12) any other application requirements that may be established by the Department by rule.

(j) (Blank). ~~A conversion project funded in whole or in part by a grant under this Section is exempt from the requirements of the Illinois Health Facilities Planning Act. The Department of Public Health, however, shall send to the Health Facilities and Services Review Board a copy of each grant award made under this Section.~~

(k) Applications for grants are public information, except that nursing home financial condition and any proprietary data shall be classified as nonpublic data.

(l) The Department of Public Health may award grants from the Long Term Care Civil Money Penalties Fund established under Section 1919(h)(2)(A)(ii) of the Social Security Act and 42 CFR 488.422(g) if the award meets federal requirements.

(m) The Nursing Home Conversion Fund is created as a special fund in the State treasury. Moneys appropriated by the General Assembly or transferred from other sources for the purposes of this Section shall be deposited into the Fund. All interest earned on moneys in the fund shall be credited to the fund. Moneys contained in the fund shall be used to support the purposes of this Section.

(Source: P.A. 95-331, eff. 8-21-07; 96-31, eff. 6-30-09; 96-758, eff. 8-25-09; 96-1000, eff. 7-2-10.)

(405 ILCS 25/4.03 rep.) (from Ch. 91 1/2, par. 604.03)

Section 120. The Specialized Living Centers Act is amended by repealing Section 4.03.

Section 999. Effective date. This Act takes effect upon becoming law.

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