AN ACT concerning State government.

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

Section 5. The Illinois Health Facilities Planning Act is amended by changing Sections 3, 4.2, 5, 5.4, 6, and 12 as follows:

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

(Section scheduled to be repealed on December 31, 2019)

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

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

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

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

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

(A) If a demonstration project under the Nursing Home Care Act applies for a certificate of need to convert to a nursing facility, it shall meet the licensure and certificate of need requirements in

effect as of the date of application.

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

(3.5) Skilled and intermediate care facilities licensed under the ID/DD Community Care Act or the MC/DD Act. No permit or exemption is required for a facility licensed under the ID/DD Community Care Act or the MC/DD Act prior to the reduction of the number of beds at a facility. If there is a total reduction of beds at a facility licensed under the ID/DD Community Care Act or the MC/DD Act, this is a discontinuation or closure of the facility. If a facility licensed under the ID/DD Community Care Act or the MC/DD Act reduces the number of beds or discontinues the facility, that facility must notify the Board as provided in Section 14.1 of this Act.

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

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

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

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

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

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

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

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

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

is in excess of the capital expenditure minimum.

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

(1) Federally-owned facilities.

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

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

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

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

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

(7) The closure of an entity or a portion of an entity

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

(8) Any change of ownership of a health care facility that is licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the exception of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care Act.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or

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

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

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

financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" or "Board" means the Health Facilities and Services Review Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion project undertaken in accordance with Section 30 of the Older Adult Services Act shall be excluded from any obligations under this Act.

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

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum,

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

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

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or

submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $11,500,000 for projects by hospital applicants, $6,500,000 for applicants for projects related to skilled and intermediate care long-term care facilities licensed under the Nursing Home Care Act, and $3,000,000 for projects by all other applicants, which shall be annually adjusted to reflect the increase in construction costs due to inflation, for major medical equipment and for all other capital expenditures.

"Financial Commitment" means the commitment of at least 33% of total funds assigned to cover total project cost, which occurs by the actual expenditure of 33% or more of the total project cost or the commitment to expend 33% or more of the total project cost by signed contracts or other legal means.

"Non-clinical service area" means an area (i) for the

benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.

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

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be

considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

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

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

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

"Agency" or "Department" means the Illinois Department of Public Health.

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

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

construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

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

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

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

"Freestanding emergency center" means a facility subject to licensure under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include

subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice of a physician or other licensed health care professional while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

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

(Source: P.A. 98-414, eff. 1-1-14; 98-629, eff. 1-1-15; 98-651, eff. 6-16-14; 98-1086, eff. 8-26-14; 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-527, eff. 1-1-17.)

(20 ILCS 3960/4.2)

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

Sec. 4.2. Ex parte communications.

(a) Except in the disposition of matters that agencies are authorized by law to entertain or dispose of on an ex parte basis including, but not limited to rule making, the State Board, any State Board member, employee, or a hearing officer shall not engage in ex parte communication in connection with the substance of any formally filed application for a permit with any person or party or the representative of any party.

This subsection (a) applies when the Board, member, employee, or hearing officer knows, or should know upon reasonable inquiry, that the application or exemption has been formally filed with the Board. Nothing in this Section shall prohibit staff members from providing technical assistance to applicants. Nothing in this Section shall prohibit staff from verifying or clarifying an applicant's information as it prepares the State Board Staff Report ~~staff report~~. Once an application or exemption is filed and deemed complete, a written record of any communication between staff and an applicant shall be prepared by staff and made part of the public record, using a prescribed, standardized format, and shall be included in the application file.

(b) A State Board member or employee may communicate with other members or employees and any State Board member or hearing officer may have the aid and advice of one or more personal assistants.

(c) An ex parte communication received by the State Board, any State Board member, employee, or a hearing officer shall be made a part of the record of the matter, including all written communications, all written responses to the communications, and a memorandum stating the substance of all oral communications and all responses made and the identity of each person from whom the ex parte communication was received.

(d) "Ex parte communication" means a communication between a person who is not a State Board member or employee and a

State Board member or employee that reflects on the substance of a pending or impending State Board proceeding and that takes place outside the record of the proceeding. Communications regarding matters of procedure and practice, such as the format of pleading, number of copies required, manner of service, and status of proceedings, are not considered ex parte communications. Technical assistance with respect to an application, not intended to influence any decision on the application, may be provided by employees to the applicant. Any assistance shall be documented in writing by the applicant and employees within 10 business days after the assistance is provided.

(e) For purposes of this Section, "employee" means a person the State Board or the Agency employs on a full-time, part-time, contract, or intern basis.

(f) The State Board, State Board member, or hearing examiner presiding over the proceeding, in the event of a violation of this Section, must take whatever action is necessary to ensure that the violation does not prejudice any party or adversely affect the fairness of the proceedings.

(g) Nothing in this Section shall be construed to prevent the State Board or any member of the State Board from consulting with the attorney for the State Board.

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

(20 ILCS 3960/5) (from Ch. 111 1/2, par. 1155)

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

Sec. 5. Construction, modification, or establishment of health care facilities or acquisition of major medical equipment; permits or exemptions. No person shall construct, modify or establish a health care facility or acquire major medical equipment without first obtaining a permit or exemption from the State Board. The State Board shall not delegate to the staff of the State Board or any other person or entity the authority to grant permits or exemptions whenever the staff or other person or entity would be required to exercise any discretion affecting the decision to grant a permit or exemption. The State Board may, by rule, delegate authority to the Chairman to grant permits or exemptions when applications meet all of the State Board's review criteria and are unopposed.

A permit or exemption shall be obtained prior to the acquisition of major medical equipment or to the construction or modification of a health care facility which:

(a) requires a total capital expenditure in excess of the capital expenditure minimum; or

(b) substantially changes the scope or changes the functional operation of the facility; or

(c) changes the bed capacity of a health care facility by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more

than 20 beds or more than 10% of total bed capacity as defined by the State Board, whichever is less, over a 2 year period.

A permit shall be valid only for the defined construction or modifications, site, amount and person named in the application for such permit and shall not be transferable or assignable. A permit shall be valid until such time as the project has been completed, provided that the project commences and proceeds to completion with due diligence by the completion date or extension date approved by the Board.

A permit holder must do the following: (i) submit the final completion and cost report for the project within 90 days after the approved project completion date or extension date and (ii) submit annual progress reports no earlier than 30 days before and no later than 30 days after each anniversary date of the Board's approval of the permit until the project is completed. To maintain a valid permit and to monitor progress toward project commencement and completion, routine post-permit reports shall be limited to annual progress reports and the final completion and cost report. Annual progress reports shall include information regarding the committed funds expended toward the approved project. <u>For projects to be completed in 12 months or less, the permit holder shall report financial commitment in the final completion and cost report. For projects to be completed between 12 to 24 months, the permit holder shall report financial commitment in the first annual</u>

report. For projects to be completed in more than 24 months, the permit holder shall report financial commitment in the second annual progress report. The ~~If the project is not completed in one year, then, by the second annual report, the permit holder shall expend 33% or more of the total project cost or shall make a commitment to expend 33% or more of the total project cost by signed contracts or other legal means, and the~~ report shall contain information regarding financial commitment ~~those~~ expenditures or commitments. ~~If the project is to be completed in one year, then the first annual report shall contain the expenditure commitment information for the total project cost.~~ The State Board may extend the financial ~~expenditure~~ commitment period after considering a permit holder's showing of good cause and request for additional time to complete the project.

The Certificate of Need process required under this Act is designed to restrain rising health care costs by preventing unnecessary construction or modification of health care facilities. The Board must assure that the establishment, construction, or modification of a health care facility or the acquisition of major medical equipment is consistent with the public interest and that the proposed project is consistent with the orderly and economic development or acquisition of those facilities and equipment and is in accord with the standards, criteria, or plans of need adopted and approved by the Board. Board decisions regarding the construction of health

care facilities must consider capacity, quality, value, and equity. Projects may deviate from the costs, fees, and expenses provided in their project cost information for the project's cost components, provided that the final total project cost does not exceed the approved permit amount. Project alterations shall not increase the total approved permit amount by more than the limit set forth under the Board's rules.

Major construction projects, for the purposes of this Act, shall include but are not limited to: projects for the construction of new buildings; additions to existing facilities; modernization projects whose cost is in excess of $1,000,000 or 10% of the facilities' operating revenue, whichever is less; and such other projects as the State Board shall define and prescribe pursuant to this Act.

The acquisition by any person of major medical equipment that will not be owned by or located in a health care facility and that will not be used to provide services to inpatients of a health care facility shall be exempt from review provided that a notice is filed in accordance with exemption requirements.

Notwithstanding any other provision of this Act, no permit or exemption is required for the construction or modification of a non-clinical service area of a health care facility.

(Source: P.A. 97-1115, eff. 8-27-12; 98-414, eff. 1-1-14.)

(20 ILCS 3960/5.4)

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

Sec. 5.4. Safety Net Impact Statement.

(a) General review criteria shall include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities licensed under the Nursing Home Care Act, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

(b) For the purposes of this Section, "safety net services" are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. Safety net service providers include, but are not limited to, hospitals and private practice physicians that provide charity care, school-based health centers, migrant health clinics, rural health clinics, federally qualified health centers, community health centers, public health departments, and community mental health centers.

(c) As developed by the applicant, a Safety Net Impact Statement shall describe all of the following:

(1) The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

(2) The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

(3) How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

(d) Safety Net Impact Statements shall also include all of the following:

(1) For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

(2) For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the State Board regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

(3) Any information the applicant believes is directly

relevant to safety net services, including information regarding teaching, research, and any other service.

(e) The Board staff shall publish a notice, that an application accompanied by a Safety Net Impact Statement has been filed, in a newspaper having general circulation within the area affected by the application. If no newspaper has a general circulation within the county, the Board shall post the notice in 5 conspicuous places within the proposed area.

(f) Any person, community organization, provider, or health system or other entity wishing to comment upon or oppose the application may file a Safety Net Impact Statement Response with the Board, which shall provide additional information concerning a project's impact on safety net services in the community.

(g) Applicants shall be provided an opportunity to submit a reply to any Safety Net Impact Statement Response.

(h) The State Board Staff Report ~~staff report~~ shall include a statement as to whether a Safety Net Impact Statement was filed by the applicant and whether it included information on charity care, the amount of care provided to Medicaid patients, and information on teaching, research, or any other service provided by the applicant directly relevant to safety net services. The report shall also indicate the names of the parties submitting responses and the number of responses and replies, if any, that were filed.

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

(20 ILCS 3960/6) (from Ch. 111 1/2, par. 1156)

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

Sec. 6. Application for permit or exemption; exemption regulations.

(a) An application for a permit or exemption shall be made to the State Board upon forms provided by the State Board. This application shall contain such information as the State Board deems necessary. The State Board shall not require an applicant to file a Letter of Intent before an application is filed. Such application shall include affirmative evidence on which the State Board or Chairman may make its decision on the approval or denial of the permit or exemption.

(b) The State Board shall establish by regulation the procedures and requirements regarding issuance of exemptions. An exemption shall be approved when information required by the Board by rule is submitted. Projects eligible for an exemption, rather than a permit, include, but are not limited to, change of ownership of a health care facility, discontinuation of a category of service, and discontinuation of a health care facility, other than a health care facility maintained by the State or any agency or department thereof or a nursing home maintained by a county. For a change of ownership of a health care facility, the State Board shall provide by rule for an expedited process for obtaining an exemption in accordance with Section 8.5 of this Act. In connection with a change of

ownership, the State Board may approve the transfer of an existing permit without regard to whether the permit to be transferred has yet been obligated, except for permits establishing a new facility or a new category of service.

(c) All applications shall be signed by the applicant and shall be verified by any 2 officers thereof.

(c-5) Any written review or findings of the Board staff ~~or any other reviewing organization under Section 8~~ concerning an application for a permit must be made available to the public at least 14 calendar days before the meeting of the State Board at which the review or findings are considered. The applicant and members of the public may submit, to the State Board, written responses regarding the facts set forth in the review or findings of the Board staff or reviewing organization. Members of the public shall have until 10 days before the meeting of the State Board to submit any written response concerning the Board staff's written review or findings. The Board staff may revise any findings to address corrections of factual errors cited in the public response. At the meeting, the State Board may, in its discretion, permit the submission of other additional written materials.

(d) Upon receipt of an application for a permit, the State Board shall approve and authorize the issuance of a permit if it finds (1) that the applicant is fit, willing, and able to provide a proper standard of health care service for the community with particular regard to the qualification,

background and character of the applicant, (2) that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community, (3) that safeguards are provided which assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest, and (4) that the proposed project is consistent with the orderly and economic development of such facilities and equipment and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act.

(Source: P.A. 99-154, eff. 7-28-15.)

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

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

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

(1) Prescribe rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of

project reviewed and which are required to carry out the provisions and purposes of this Act. Policies and procedures of the State Board shall take into consideration the priorities and needs of medically underserved areas and other health care services, giving special consideration to the impact of projects on access to safety net services.

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

(3) (Blank).

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, maintain an updated inventory on the Board's web site reflecting the most recent bed and service changes and updated need determinations when new census data become available or new need formulae are adopted, and develop health care facility plans which shall be utilized in the review of applications for permit under this Act. Such health facility plans shall be coordinated by the Board with pertinent State Plans. Inventories pursuant to this Section of skilled or intermediate care facilities licensed under the Nursing Home Care Act, skilled or intermediate care facilities licensed under the ID/DD Community Care Act, skilled or intermediate care facilities licensed under the MC/DD Act, facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013, or nursing homes licensed under the Hospital

Licensing Act shall be conducted on an annual basis no later than July 1 of each year and shall include among the information requested a list of all services provided by a facility to its residents and to the community at large and differentiate between active and inactive beds.

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

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

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

(c) The extent of utilization of existing facilities;

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

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

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

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

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

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis

for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

(5) Coordinate with other state agencies having responsibilities affecting health care facilities, including those of licensure and cost reporting.

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

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

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

Six months after June 30, 2009 (the effective date of Public Act 96-31), substantive projects shall include no more than the following:

(a) Projects to construct (1) a new or replacement facility located on a new site or (2) a replacement

facility located on the same site as the original facility and the cost of the replacement facility exceeds the capital expenditure minimum, which shall be reviewed by the Board within 120 days;

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

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

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

Such rules shall not prevent the conduct of a public hearing upon the timely request of an interested party. Such reviews shall not exceed 60 days from the date the application is declared to be complete.

(9) Prescribe rules, regulations, standards, and criteria pertaining to the granting of permits for construction and

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

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

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

(11) Issue written decisions upon request of the applicant or an adversely affected party to the Board. Requests for a written decision shall be made within 15 days after the Board meeting in which a final decision has been made. A "final decision" for purposes of this Act is the decision to approve or deny an application, or take other actions permitted under this Act, at the time and date of the meeting that such action is scheduled by the Board. The transcript of the State Board meeting shall be incorporated into the Board's final decision. The staff of the Board shall prepare a written copy of the final decision and the Board shall approve a final copy for

inclusion in the formal record. The Board shall consider, for approval, the written draft of the final decision no later than the next scheduled Board meeting. The written decision shall identify the applicable criteria and factors listed in this Act and the Board's regulations that were taken into consideration by the Board when coming to a final decision. If the Board denies or fails to approve an application for permit or exemption, the Board shall include in the final decision a detailed explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill.

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

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

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

(15) Establish a separate set of rules and guidelines for long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities. An open and transparent process shall be developed that considers the following: how skilled nursing fits in the continuum of care with other care providers, modernization of nursing homes, establishment of more private rooms,

development of alternative services, and current trends in long-term care services. The Chairman of the Board shall appoint a permanent Health Services Review Board Long-term Care Facility Advisory Subcommittee that shall develop and recommend to the Board the rules to be established by the Board under this paragraph (15). The Subcommittee shall also provide continuous review and commentary on policies and procedures relative to long-term care and the review of related projects. The Subcommittee shall make recommendations to the Board no later than January 1, 2016 and every January thereafter pursuant to the Subcommittee's responsibility for the continuous review and commentary on policies and procedures relative to long-term care. In consultation with other experts from the health field of long-term care, the Board and the Subcommittee shall study new approaches to the current bed need formula and Health Service Area boundaries to encourage flexibility and innovation in design models reflective of the changing long-term care marketplace and consumer preferences and submit its recommendations to the Chairman of the Board no later than January 1, 2017. The Subcommittee shall evaluate, and make recommendations to the State Board regarding, the buying, selling, and exchange of beds between long-term care facilities within a specified geographic area or drive time. The Board shall file the proposed related administrative rules for the separate rules and guidelines for long-term care required by this paragraph (15) by no later than September 30,

2011. The Subcommittee shall be provided a reasonable and timely opportunity to review and comment on any review, revision, or updating of the criteria, standards, procedures, and rules used to evaluate project applications as provided under Section 12.3 of this Act.

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

One representative from the Department of Public Health, the Department of Healthcare and Family Services, the Department on Aging, and the Department of Human Services may each serve as an ex-officio non-voting member of the Subcommittee. The Chairman of the Board shall select a Subcommittee Chair, who shall serve for a period of 3 years.

(16) Prescribe the format of the State Board Staff Report. A State Board Staff Report shall pertain to applications that include, but are not limited to, applications for permit or exemption, applications for permit renewal, applications for

extension of the financial commitment ~~obligation~~ period, applications requesting a declaratory ruling, or applications under the Health Care Worker Self-Referral Act. State Board Staff Reports shall compare applications to the relevant review criteria under the Board's rules.

(17) Establish a separate set of rules and guidelines for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. An application for the re-establishment of a facility in connection with the relocation of the facility shall not be granted unless the applicant has a contractual relationship with at least one hospital to provide emergency and inpatient mental health services required by facility consumers, and at least one community mental health agency to provide oversight and assistance to facility consumers while living in the facility, and appropriate services, including case management, to assist them to prepare for discharge and reside stably in the community thereafter. No new facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall be established after June 16, 2014 (the effective date of Public Act 98-651) except in connection with the relocation of an existing facility to a new location. An application for a new location shall not be approved unless there are adequate community services accessible to the consumers within a reasonable distance, or by use of public transportation, so as to facilitate the goal of achieving maximum individual

self-care and independence. At no time shall the total number of authorized beds under this Act in facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 exceed the number of authorized beds on June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 98-414, eff. 1-1-14; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-1086, eff. 8-26-14; 99-78, eff. 7-20-15; 99-114, eff. 7-23-15; 99-180, eff. 7-29-15; 99-277, eff. 8-5-15; 99-527, eff. 1-1-17; 99-642, eff. 7-28-16.)

Section 10. The Alternative Health Care Delivery Act is amended by changing Section 35 as follows:

(210 ILCS 3/35)

Sec. 35. Alternative health care models authorized. Notwithstanding any other law to the contrary, alternative health care models described in this Section may be established on a demonstration basis.

(1) (Blank).

(2) Alternative health care delivery model; postsurgical recovery care center. A postsurgical recovery care center is a designated site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that potentially require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting.

Patients may be discharged from the postsurgical recovery care center in less than 24 hours if the attending physician or the facility's medical director believes the patient has recovered enough to be discharged. A postsurgical recovery care center is either freestanding or a defined unit of an ambulatory surgical treatment center or hospital. No facility, or portion of a facility, may participate in a demonstration program as a postsurgical recovery care center unless the facility has been licensed as an ambulatory surgical treatment center or hospital for at least 2 years before August 20, 1993 (the effective date of Public Act 88-441). The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 48 hours unless the treating physician requests an extension of time from the recovery center's medical director on the basis of medical or clinical documentation that an additional care period is required for the recovery of a patient and the medical director approves the extension of time. In no case, however, shall a patient's length of stay in a postsurgical recovery care center be longer than 72 hours. If a patient requires an additional care period after the expiration of the 72-hour limit, the patient shall be transferred to an appropriate facility. Reports on variances from the 24-hour or 48-hour limit shall be sent to the Department for its evaluation. The reports shall, before submission to the Department,

have removed from them all patient and physician identifiers. Blood products may be administered in the postsurgical recovery care center model. In order to handle cases of complications, emergencies, or exigent circumstances, every postsurgical recovery care center as defined in this paragraph shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital. A postsurgical recovery care center shall be no larger than 20 beds. A postsurgical recovery care center shall be located within 15 minutes travel time from the general acute care hospital with which the center maintains a contractual relationship, including a transfer agreement, as required under this paragraph.

No postsurgical recovery care center shall discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

The Department shall adopt rules to implement the provisions of Public Act 88-441 concerning postsurgical recovery care centers within 9 months after August 20, 1993. Notwithstanding any other law to the contrary, a postsurgical recovery care center model may provide sleep laboratory or similar sleep studies in accordance with applicable State and federal laws and regulations.

(3) Alternative health care delivery model; children's community-based health care center. A children's

community-based health care center model is a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term stays and 120 days to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. This care is to be provided in a home-like environment that serves no more than 12 children at a time, except that a children's community-based health care center in existence on the effective date of this amendatory Act of the 100th General Assembly that is located in Chicago on grade level for Life Safety Code purposes may provide care to no more than 16 children at a time. Children's community-based health care center services must be available through the model to all families, including those whose care is paid for through the Department of Healthcare and Family Services, the Department of Children and Family Services, the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home.

Each children's community-based health care center model location shall be physically separate and apart from any other facility licensed by the Department of Public Health under this or any other Act and shall provide the

following services: respite care, registered nursing or licensed practical nursing care, transitional care to facilitate home placement or other appropriate settings and reunite families, medical day care, weekend camps, and diagnostic studies typically done in the home setting.

Coverage for the services provided by the Department of Healthcare and Family Services under this paragraph (3) is contingent upon federal waiver approval and is provided only to Medicaid eligible clients participating in the home and community based services waiver designated in Section 1915(c) of the Social Security Act for medically frail and technologically dependent children or children in Department of Children and Family Services foster care who receive home health benefits.

(4) Alternative health care delivery model; community based residential rehabilitation center. A community-based residential rehabilitation center model is a designated site that provides rehabilitation or support, or both, for persons who have experienced severe brain injury, who are medically stable, and who no longer require acute rehabilitative care or intense medical or nursing services. The average length of stay in a community-based residential rehabilitation center shall not exceed 4 months. As an integral part of the services provided, individuals are housed in a supervised living setting while having immediate access to the community. The residential

rehabilitation center authorized by the Department may have more than one residence included under the license. A residence may be no larger than 12 beds and shall be located as an integral part of the community. Day treatment or individualized outpatient services shall be provided for persons who reside in their own home. Functional outcome goals shall be established for each individual. Services shall include, but are not limited to, case management, training and assistance with activities of daily living, nursing consultation, traditional therapies (physical, occupational, speech), functional interventions in the residence and community (job placement, shopping, banking, recreation), counseling, self-management strategies, productive activities, and multiple opportunities for skill acquisition and practice throughout the day. The design of individualized program plans shall be consistent with the outcome goals that are established for each resident. The programs provided in this setting shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The program shall have been accredited by CARF as a Brain Injury Community-Integrative Program for at least 3 years.

(5) Alternative health care delivery model; Alzheimer's disease management center. An Alzheimer's disease management center model is a designated site that provides a safe and secure setting for care of persons

diagnosed with Alzheimer's disease. An Alzheimer's disease management center model shall be a facility separate from any other facility licensed by the Department of Public Health under this or any other Act. An Alzheimer's disease management center shall conduct and document an assessment of each resident every 6 months. The assessment shall include an evaluation of daily functioning, cognitive status, other medical conditions, and behavioral problems. An Alzheimer's disease management center shall develop and implement an ongoing treatment plan for each resident. The treatment plan shall have defined goals. The Alzheimer's disease management center shall treat behavioral problems and mood disorders using nonpharmacologic approaches such as environmental modification, task simplification, and other appropriate activities. All staff must have necessary training to care for all stages of Alzheimer's Disease. An Alzheimer's disease management center shall provide education and support for residents and caregivers. The education and support shall include referrals to support organizations for educational materials on community resources, support groups, legal and financial issues, respite care, and future care needs and options. The education and support shall also include a discussion of the resident's need to make advance directives and to identify surrogates for medical and legal decision-making. The provisions of this paragraph

establish the minimum level of services that must be provided by an Alzheimer's disease management center. An Alzheimer's disease management center model shall have no more than 100 residents. Nothing in this paragraph (5) shall be construed as prohibiting a person or facility from providing services and care to persons with Alzheimer's disease as otherwise authorized under State law.

(6) Alternative health care delivery model; birth center. A birth center shall be exclusively dedicated to serving the childbirth-related needs of women and their newborns and shall have no more than 10 beds. A birth center is a designated site that is away from the mother's usual place of residence and in which births are planned to occur following a normal, uncomplicated, and low-risk pregnancy. A birth center shall offer prenatal care and community education services and shall coordinate these services with other health care services available in the community.

(A) A birth center shall not be separately licensed if it is one of the following:

(1) A part of a hospital; or

(2) A freestanding facility that is physically distinct from a hospital but is operated under a license issued to a hospital under the Hospital Licensing Act.

(B) A separate birth center license shall be

required if the birth center is operated as:

(1) A part of the operation of a federally qualified health center as designated by the United States Department of Health and Human Services; or

(2) A facility other than one described in subparagraph (A)(1), (A)(2), or (B)(1) of this paragraph (6) whose costs are reimbursable under Title XIX of the federal Social Security Act.

In adopting rules for birth centers, the Department shall consider: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code. The Department's rules shall stipulate the eligibility criteria for birth center admission. The Department's rules shall stipulate the necessary equipment for emergency care according to the American Association of Birth Centers' standards and any additional equipment deemed necessary by the Department. The Department's rules shall provide for a time period within which each birth center not part of a hospital must become accredited by either the Commission for the Accreditation of Freestanding Birth Centers or The Joint Commission.

A birth center shall be certified to participate in the

Medicare and Medicaid programs under Titles XVIII and XIX, respectively, of the federal Social Security Act. To the extent necessary, the Illinois Department of Healthcare and Family Services shall apply for a waiver from the United States Health Care Financing Administration to allow birth centers to be reimbursed under Title XIX of the federal Social Security Act.

A birth center that is not operated under a hospital license shall be located within a ground travel time distance from the general acute care hospital with which the birth center maintains a contractual relationship, including a transfer agreement, as required under this paragraph, that allows for an emergency caesarian delivery to be started within 30 minutes of the decision a caesarian delivery is necessary. A birth center operating under a hospital license shall be located within a ground travel time distance from the licensed hospital that allows for an emergency caesarian delivery to be started within 30 minutes of the decision a caesarian delivery is necessary.

The services of a medical director physician, licensed to practice medicine in all its branches, who is certified or eligible for certification by the American College of Obstetricians and Gynecologists or the American Board of Osteopathic Obstetricians and Gynecologists or has hospital obstetrical privileges are required in birth centers. The medical director in consultation with the

Director of Nursing and Midwifery Services shall coordinate the clinical staff and overall provision of patient care. The medical director or his or her physician designee shall be available on the premises or within a close proximity as defined by rule. The medical director and the Director of Nursing and Midwifery Services shall jointly develop and approve policies defining the criteria to determine which pregnancies are accepted as normal, uncomplicated, and low-risk, and the anesthesia services available at the center. No general anesthesia may be administered at the center.

If a birth center employs certified nurse midwives, a certified nurse midwife shall be the Director of Nursing and Midwifery Services who is responsible for the development of policies and procedures for services as provided by Department rules.

An obstetrician, family practitioner, or certified nurse midwife shall attend each woman in labor from the time of admission through birth and throughout the immediate postpartum period. Attendance may be delegated only to another physician or certified nurse midwife. Additionally, a second staff person shall also be present at each birth who is licensed or certified in Illinois in a health-related field and under the supervision of the physician or certified nurse midwife in attendance, has specialized training in labor and delivery techniques and

care of newborns, and receives planned and ongoing training as needed to perform assigned duties effectively.

The maximum length of stay in a birth center shall be consistent with existing State laws allowing a 48-hour stay or appropriate post-delivery care, if discharged earlier than 48 hours.

A birth center shall participate in the Illinois Perinatal System under the Developmental Disability Prevention Act. At a minimum, this participation shall require a birth center to establish a letter of agreement with a hospital designated under the Perinatal System. A hospital that operates or has a letter of agreement with a birth center shall include the birth center under its maternity service plan under the Hospital Licensing Act and shall include the birth center in the hospital's letter of agreement with its regional perinatal center.

A birth center may not discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

No general anesthesia and no surgery may be performed at a birth center. The Department may by rule add birth center patient eligibility criteria or standards as it deems necessary. The Department shall by rule require each birth center to report the information which the Department shall make publicly available, which shall include, but is not limited to, the following:

(i) Birth center ownership.

(ii) Sources of payment for services.

(iii) Utilization data involving patient length of stay.

(iv) Admissions and discharges.

(v) Complications.

(vi) Transfers.

(vii) Unusual incidents.

(viii) Deaths.

(ix) Any other publicly reported data required under the Illinois Consumer Guide.

(x) Post-discharge patient status data where patients are followed for 14 days after discharge from the birth center to determine whether the mother or baby developed a complication or infection.

Within 9 months after the effective date of this amendatory Act of the 95th General Assembly, the Department shall adopt rules that are developed with consideration of: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code.

The Department shall adopt other rules as necessary to implement the provisions of this amendatory Act of the 95th General Assembly within 9 months after the effective date

of this amendatory Act of the 95th General Assembly.

(Source: P.A. 97-135, eff. 7-14-11; 97-987, eff. 1-1-13.)