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 Act on the Aging is amended by adding Section 4.01a as follows:

(20 ILCS 105/4.01a new)

Sec. 4.01a. Use of certain moneys deposited into the Department on Aging State Projects Fund. All moneys transferred into the Department on Aging State Projects Fund from the Long-Term Care Provider Fund shall, subject to appropriation, be used for older adult services, as described in subsection (f) of Section 20 of the Older Adult Services Act. All federal moneys received as a result of expenditures of such moneys shall be deposited into the Department of Human Services Community Services Fund.

Section 10. The Department of Human Services Act is amended by adding Section 1-50 as follows:

(20 ILCS 1305/1-50 new)

Sec. 1-50. Department of Human Services Community Services Fund.

(a) The Department of Human Services Community Services

Fund is created in the State treasury as a special fund.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Section. Disbursements from the Fund shall be made, subject to appropriation, for payment of expenses incurred by the Department of Human Services in support of the Department's rebalancing services.

(c) The Fund shall consist of the following:

(1) Moneys transferred from another State fund.

(2) All federal moneys received as a result of expenditures that are attributable to moneys deposited in the Fund.

(3) All other moneys received for the Fund from any other source.

(4) Interest earned upon moneys in the Fund.

Section 15. The State Finance Act is amended by adding Section 5.786 as follows:

(30 ILCS 105/5.786 new)

Sec. 5.786. The Department of Human Services Community Services Fund.

Section 20. The State Prompt Payment Act is amended by changing Section 3-2 as follows:

(30 ILCS 540/3-2)

Sec. 3-2. Beginning July 1, 1993, in any instance where a State official or agency is late in payment of a vendor's bill or invoice for goods or services furnished to the State, as defined in Section 1, properly approved in accordance with rules promulgated under Section 3-3, the State official or agency shall pay interest to the vendor in accordance with the following:

(1) Any bill, except a bill submitted under Article V of the Illinois Public Aid Code, approved for payment under this Section must be paid or the payment issued to the payee within 60 days of receipt of a proper bill or invoice. If payment is not issued to the payee within this 60 day period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60 day period, until final payment is made. Any bill, except a bill for pharmacy or nursing facility services or goods, submitted under Article V of the Illinois Public Aid Code approved for payment under this Section must be paid or the payment issued to the payee within 60 days after receipt of a proper bill or invoice, and, if payment is not issued to the payee within this 60-day period, an interest penalty of 2.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60-day period, until final payment is made. Any bill for pharmacy

or nursing facility services or goods submitted under Article V of the Illinois Public Aid Code, approved for payment under this Section must be paid or the payment issued to the payee within 60 days of receipt of a proper bill or invoice. If payment is not issued to the payee within this 60-day period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60-day period, until final payment is made.

(1.1) A State agency shall review in a timely manner each bill or invoice after its receipt. If the State agency determines that the bill or invoice contains a defect making it unable to process the payment request, the agency shall notify the vendor requesting payment as soon as possible after discovering the defect pursuant to rules promulgated under Section 3-3; provided, however, that the notice for construction related bills or invoices must be given not later than 30 days after the bill or invoice was first submitted. The notice shall identify the defect and any additional information necessary to correct the defect. If one or more items on a construction related bill or invoice are disapproved, but not the entire bill or invoice, then the portion that is not disapproved shall be paid.

(2) Where a State official or agency is late in payment of a vendor's bill or invoice properly approved in

accordance with this Act, and different late payment terms are not reduced to writing as a contractual agreement, the State official or agency shall automatically pay interest penalties required by this Section amounting to $50 or more to the appropriate vendor. Each agency shall be responsible for determining whether an interest penalty is owed and for paying the interest to the vendor. Interest due to a vendor that amounts to less than $50 shall not be paid but shall be accrued until all interest due the vendor for all similar warrants exceeds $50, at which time the accrued interest shall be payable and interest will begin accruing again, except that interest accrued as of the end of the fiscal year that does not exceed $50 shall be payable at that time. In the event an individual has paid a vendor for services in advance, the provisions of this Section shall apply until payment is made to that individual.

(Source: P.A. 96-555, eff. 8-18-09; 96-802, eff. 1-1-10; 96-959, eff. 7-1-10; 96-1000, eff. 7-2-10.)

Section 25. The Nursing Home Care Act is amended by changing Section 3-103 as follows:

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

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

(1) Application to operate a facility shall be made to

the Department on forms furnished by the Department.

(2) All license applications shall be accompanied with an application fee. The fee for an annual license shall be $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 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 of this Act, for the enforcement of this Act, 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. ~~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. 96-758, eff. 8-25-09; 96-1372, eff. 7-29-10.)

Section 30. The Illinois Public Aid Code is amended by changing Sections 5-1.1, 5-5.2, 5-5.3, 5-5.4, 5-5.4a, 5-5.5, 5-5.5a, 5-5.6b, 5-5.7, 5-5.8b, 5-5.11, 5A-2, 5A-3, 5A-5, 5A-8, 5A-10, 5A-14, 5B-1, 5B-2, 5B-4, 5B-5, and 5B-8 as follows:

(305 ILCS 5/5-1.1) (from Ch. 23, par. 5-1.1)

Sec. 5-1.1. Definitions. The terms defined in this Section shall have the meanings ascribed to them, except when the context otherwise requires.

(a) "Nursing ~~Skilled nursing~~ facility" means a ~~nursing home eligible to participate as a skilled nursing~~ facility, licensed

by the Department of Public Health under the Nursing Home Care Act, that provides nursing facility services within the meaning of ~~under~~ Title XIX of the federal Social Security Act.

(b) "Intermediate care facility for the developmentally disabled" or "ICF/DD" means a ~~nursing home eligible to participate as an intermediate care~~ facility, licensed by the Department of Public Health under the MR/DD Community Care Act, that is an intermediate care facility for the mentally retarded within the meaning of ~~under~~ Title XIX of the federal Social Security Act.

(c) "Standard services" means those services required for the care of all patients in the facility and shall, as a minimum, include the following: (1) administration; (2) dietary (standard); (3) housekeeping; (4) laundry and linen; (5) maintenance of property and equipment, including utilities; (6) medical records; (7) training of employees; (8) utilization review; (9) activities services; (10) social services; (11) disability services; and all other similar services required by either the laws of the State of Illinois or one of its political subdivisions or municipalities or by Title XIX of the Social Security Act.

(d) "Patient services" means those which vary with the number of personnel; professional and para-professional skills of the personnel; specialized equipment, and reflect the intensity of the medical and psycho-social needs of the patients. Patient services shall as a minimum include: (1)

physical services; (2) nursing services, including restorative nursing; (3) medical direction and patient care planning; (4) health related supportive and habilitative services and all similar services required by either the laws of the State of Illinois or one of its political subdivisions or municipalities or by Title XIX of the Social Security Act.

(e) "Ancillary services" means those services which require a specific physician's order and defined as under the medical assistance program as not being routine in nature for skilled nursing facilities and ICF/DDs ~~intermediate care facilities~~. Such services generally must be authorized prior to delivery and payment as provided for under the rules of the Department of Healthcare and Family Services.

(f) "Capital" means the investment in a facility's assets for both debt and non-debt funds. Non-debt capital is the difference between an adjusted replacement value of the assets and the actual amount of debt capital.

(g) "Profit" means the amount which shall accrue to a facility as a result of its revenues exceeding its expenses as determined in accordance with generally accepted accounting principles.

(h) "Non-institutional services" means those services provided under paragraph (f) of Section 3 of the Disabled Persons Rehabilitation Act and those services provided under Section 4.02 of the Illinois Act on the Aging.

(i) "Exceptional medical care" means the level of medical

care required by persons who are medically stable for discharge from a hospital but who require acute intensity hospital level care for physician, nurse and ancillary specialist services, including persons with acquired immunodeficiency syndrome (AIDS) or a related condition. Such care shall consist of those services which the Department shall determine by rule.

(j) "Institutionalized person" means an individual who is an inpatient in an ICF/DD or ~~intermediate care or skilled~~ nursing facility, or who is an inpatient in a medical institution receiving a level of care equivalent to that of an ICF/DD or ~~intermediate care or skilled~~ nursing facility, or who is receiving services under Section 1915(c) of the Social Security Act.

(k) "Institutionalized spouse" means an institutionalized person who is expected to receive services at the same level of care for at least 30 days and is married to a spouse who is not an institutionalized person.

(l) "Community spouse" is the spouse of an institutionalized spouse.

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

Sec. 5-5.2. Payment.

(a) All nursing facilities ~~Skilled Nursing Facilities~~ that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services. ~~All Intermediate~~

~~Care Facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services.~~

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the ~~following~~ long-term care providers~~: skilled nursing facilities, intermediate care facilities, and intermediate care facilities for persons with a developmental disability. The Illinois Department shall establish billing cycles on a calendar month basis for all long-term care providers no later than July 1, 1992~~.

(c) Notwithstanding any other provisions of this Code, beginning July 1, 2012 the methodologies for reimbursement of nursing facility services as provided under this Article shall no longer be applicable for bills payable for State fiscal years 2012 and thereafter. The Department of Healthcare and Family Services shall, effective July 1, 2012, implement an evidence-based payment methodology for the reimbursement of nursing facility services. The methodology shall continue to take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Resident Assessment Instrument, adopted and in use by the federal government.

(Source: P.A. 87-809; 88-380.)

(305 ILCS 5/5-5.3) (from Ch. 23, par. 5-5.3)

Sec. 5-5.3. Conditions of Payment - Prospective Rates - Accounting Principles. This amendatory Act establishes certain conditions for the Department of ~~Public Aid (now~~ Healthcare and Family Services~~)~~ in instituting rates for the care of recipients of medical assistance in ~~skilled~~ nursing facilities and ICF/DDs ~~intermediate care facilities~~. Such conditions shall assure a method under which the payment for ~~skilled~~ nursing facility and ICF/DD ~~and intermediate care~~ services~~,~~ provided to recipients under the Medical Assistance Program shall be on a reasonable cost related basis, which is prospectively determined at least annually by the Department of Public Aid (now Healthcare and Family Services). The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. There shall be no rate increase during calendar year 1983 and the first six months of calendar year 1984.

The determination of the payment shall be made on the basis of generally accepted accounting principles that shall take into account the actual costs to the facility of providing ~~skilled~~ nursing facility and ICF/DD ~~and intermediate care~~ services to recipients under the medical assistance program.

The resultant total rate for a specified type of service shall be an amount which shall have been determined to be adequate to reimburse allowable costs of a facility that is economically and efficiently operated. The Department shall establish an effective date for each facility or group of

facilities after which rates shall be paid on a reasonable cost related basis which shall be no sooner than the effective date of this amendatory Act of 1977.

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

Sec. 5-5.4. Standards of Payment - Department of Healthcare and Family Services. The Department of Healthcare and Family Services shall develop standards of payment of ~~skilled~~ nursing facility and ICF/DD ~~and intermediate care~~ services in facilities providing such services under this Article which:

(1) Provide for the determination of a facility's payment for ~~skilled~~ nursing facility or ICF/DD ~~and intermediate care~~ services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under the MR/DD Community Care Act or the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities, Long Term Care for Under Age 22 facilities, Skilled Nursing facilities, or Intermediate Care facilities under the medical assistance program shall be prospectively established annually on the basis of historical, financial, and statistical data reflecting actual costs from prior years, which shall be applied to the current rate year and updated for inflation, except that the capital cost element for newly constructed facilities shall be based upon projected budgets. The annually established payment rate shall take

effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994 and before July 1, 2012 ~~2011~~, unless specifically provided for in this Section. The changes made by Public Act 93-841 extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1998 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1998 shall include an increase of 3% plus $1.10 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2006 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2009 shall include an increase sufficient to provide a $0.50 per hour wage

increase for non-executive staff.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% plus $3.00 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% and, for services provided on or after October 1, 1999, shall be increased by $4.00 per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must

be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now Healthcare and Family Services) shall develop the new payment methodology using the Minimum Data Set (MDS) as the instrument to collect information concerning nursing home resident condition necessary to compute the rate. The Department shall develop the new payment methodology to meet the unique needs of Illinois nursing home residents while remaining subject to the appropriations provided by the General Assembly. A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect on July 1, 2003 shall be provided for a period not exceeding 3 years and 184 days after implementation of the new payment methodology as follows:

(A) For a facility that would receive a lower nursing component rate per patient day under the new system than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be held at the level in effect on the date immediately preceding the date that the Department implements the new payment methodology until a higher nursing component rate of reimbursement is achieved by that facility.

(B) For a facility that would receive a higher nursing component rate per patient day under the payment methodology in effect on July 1, 2003 than the facility

received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be adjusted.

(C) Notwithstanding paragraphs (A) and (B), the nursing component rate per patient day for the facility shall be adjusted subject to appropriations provided by the General Assembly.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on March 1, 2001 shall include a statewide increase of 7.85%, as defined by the Department.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, except facilities participating in the Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, the numerator of the ratio used by the Department of Healthcare and Family Services to compute the rate payable under this Section using the Minimum Data Set (MDS) methodology shall incorporate the following annual amounts as the additional funds appropriated to the Department specifically to pay for rates based on the MDS nursing

component methodology in excess of the funding in effect on December 31, 2006:

(i) For rates taking effect January 1, 2007, $60,000,000.

(ii) For rates taking effect January 1, 2008, $110,000,000.

(iii) For rates taking effect January 1, 2009, $194,000,000.

(iv) For rates taking effect April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, $416,500,000 or an amount as may be necessary to complete the transition to the MDS methodology for the nursing component of the rate.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on January 1, 2008 shall be computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on April 1, 2002

shall include a statewide increase of 2.0%, as defined by the Department. This increase terminates on July 1, 2002; beginning July 1, 2002 these rates are reduced to the level of the rates in effect on March 31, 2002, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on July 1, 2001 shall be computed using the most recent cost reports on file with the Department of Public Aid no later than April 1, 2000, updated for inflation to January 1, 2001. For rates effective July 1, 2001 only, rates shall be the greater of the rate computed for July 1, 2001 or the rate effective on June 30, 2001.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the Illinois Department shall determine by rule the rates taking effect on July 1, 2002, which shall be 5.9% less than the rates in effect on June 30, 2002.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved by the United States Centers for

Medicare and Medicaid Services, the rates taking effect on July 1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on January 1, 2005 shall be 3% more than the rates in effect on December 31, 2004.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2009, the per diem support component of the rates effective on January 1, 2008, computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006, shall be increased to the amount that would have been derived using standard Department of Healthcare and Family Services methods, procedures, and inflators.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, a

socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate shall be increased by a factor of 2.53 on the first day of the month that begins at least 45 days after January 11, 2008 (the effective date of Public Act 95-707). As of August 1, 2008, the socio-development component rate shall be equal to 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53. For services provided on or after April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, whichever is later, the ~~The~~ Illinois Department may by rule adjust these socio-development component rates, and may use different adjustment methodologies for those facilities participating, and those not participating, in the Illinois Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, but in no case may such rates be diminished below those in effect on August 1, 2008.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or as long-term care facilities for residents under 22 years of age, the rates taking effect on July 1, 2003 shall include a statewide increase of 4%, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 95th General Assembly shall include a statewide increase of 2.5%, as defined by the Department.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2005, facility rates shall be increased by the difference between (i) a facility's per diem property, liability, and malpractice insurance costs as reported in the cost report filed with the Department of Public Aid and used to establish rates effective July 1, 2001 and (ii) those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations, except for adjustments required under normal auditing procedures.

Rates established effective each July 1 shall govern payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for the year beginning July 1, 1990, and for subsequent years

thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

(2) Shall take into account the actual costs incurred by facilities in providing services for recipients of skilled nursing and intermediate care services under the medical assistance program.

(3) Shall take into account the medical and psycho-social characteristics and needs of the patients.

(4) Shall take into account the actual costs incurred by facilities in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the U.S. Department of Health and Human Services pursuant to Title XIX

of the Social Security Act.

The Department of Healthcare and Family Services shall develop precise standards for payments to reimburse nursing facilities for any utilization of appropriate rehabilitative personnel for the provision of rehabilitative services which is authorized by federal regulations, including reimbursement for services provided by qualified therapists or qualified assistants, and which is in accordance with accepted professional practices. Reimbursement also may be made for utilization of other supportive personnel under appropriate supervision.

The Department shall develop enhanced payments to offset the additional costs incurred by a facility serving exceptional need residents and shall allocate at least $8,000,000 of the funds collected from the assessment established by Section 5B-2 of this Code for such payments. For the purpose of this Section, "exceptional needs" means, but need not be limited to, ventilator care, tracheotomy care, bariatric care, complex wound care, and traumatic brain injury care.

(5) Beginning July 1, 2012 the methodologies for reimbursement of nursing facility services as provided under this Section 5-5.4 shall no longer be applicable for bills payable for State fiscal years 2012 and thereafter.

(Source: P.A. 95-12, eff. 7-2-07; 95-331, eff. 8-21-07; 95-707, eff. 1-11-08; 95-744, eff. 7-18-08; 96-45, eff. 7-15-09; 96-339, eff. 7-1-10; 96-959, eff. 7-1-10; 96-1000, eff.

7-2-10.)

(305 ILCS 5/5-5.4a)

Sec. 5-5.4a. Intermediate Care Facility for the Developmentally Disabled; bed reserve payments.

The Department ~~of Public Aid~~ shall promulgate rules that ~~by October 1, 1993 which~~ establish a policy of bed reserve payments to ICF/DDs ~~Intermediate Care Facilities for the Developmentally Disabled~~ which addresses the needs of residents of ICF/DDs ~~Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)~~ and their families.

(a) When a resident of an ICF/DD ~~Intermediate Care Facility for the Developmentally Disabled (ICF/DD)~~ is absent from the facility ~~ICF/DD~~ in which he or she is a resident for purposes of physician authorized in-patient admission to a hospital, the Department's rules shall, at a minimum, provide (1) bed reserve payments at a daily rate which is 100% of the client's current per diem rate, for a period not exceeding 10 consecutive days; (2) bed reserve payments at a daily rate which is 75% of a client's current per diem rate, for a period which exceeds 10 consecutive days but does not exceed 30 consecutive days; and (3) bed reserve payments at a daily rate which is 50% of a client's current per diem rate for a period which exceeds thirty consecutive days but does not exceed 45 consecutive days.

(b) When a resident of an ICF/DD ~~Intermediate Care Facility~~

~~for the Developmentally Disabled (ICF/DD)~~ is absent from the <u>facility</u> ~~ICF/DD~~ in which he or she is a resident for purposes of a home visit with a family member the Department's rules shall, at a minimum, provide (1) bed reserve payments at a rate which is 100% of a client's current per diem rate, for a period not exceeding 10 days per State fiscal year; and (2) bed reserve payments at a rate which is 75% of a client's current per diem rate, for a period which exceeds 10 days per State fiscal year but does not exceed 30 days per State fiscal year.

(c) No Department rule regarding bed reserve payments shall require an ICF/DD to have a specified percentage of total facility occupancy as a requirement for receiving bed reserve payments.

This Section 5-5.4a shall not apply to any State operated facilities.

(Source: P.A. 91-357, eff. 7-29-99.)

(305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

Sec. 5-5.5. Elements of Payment Rate.

(a) The Department of Healthcare and Family Services shall develop a prospective method for determining payment rates for ~~skilled~~ nursing <u>facility and ICF/DD</u> ~~and intermediate care~~ services in nursing facilities composed of the following cost elements:

(1) Standard Services, with the cost of this component being determined by taking into account the actual costs to

the facilities of these services subject to cost ceilings to be defined in the Department's rules.

(2) Resident Services, with the cost of this component being determined by taking into account the actual costs, needs and utilization of these services, as derived from an assessment of the resident needs in the nursing facilities.

(3) Ancillary Services, with the payment rate being developed for each individual type of service. Payment shall be made only when authorized under procedures developed by the Department of Healthcare and Family Services.

(4) Nurse's Aide Training, with the cost of this component being determined by taking into account the actual cost to the facilities of such training.

(5) Real Estate Taxes, with the cost of this component being determined by taking into account the figures contained in the most currently available cost reports (with no imposition of maximums) updated to the midpoint of the current rate year for long term care services rendered between July 1, 1984 and June 30, 1985, and with the cost of this component being determined by taking into account the actual 1983 taxes for which the nursing homes were assessed (with no imposition of maximums) updated to the midpoint of the current rate year for long term care services rendered between July 1, 1985 and June 30, 1986.

(b) In developing a prospective method for determining

payment rates for ~~skilled~~ nursing <u>facility and ICF/DD</u> ~~and intermediate care~~ services in nursing facilities <u>and ICF/DDs</u>, the Department of Healthcare and Family Services shall consider the following cost elements:

(1) Reasonable capital cost determined by utilizing incurred interest rate and the current value of the investment, including land, utilizing composite rates, or by utilizing such other reasonable cost related methods determined by the Department. However, beginning with the rate reimbursement period effective July 1, 1987, the Department shall be prohibited from establishing, including, and implementing any depreciation factor in calculating the capital cost element.

(2) Profit, with the actual amount being produced and accruing to the providers in the form of a return on their total investment, on the basis of their ability to economically and efficiently deliver a type of service. The method of payment may assure the opportunity for a profit, but shall not guarantee or establish a specific amount as a cost.

(c) The Illinois Department may implement the amendatory changes to this Section made by this amendatory Act of 1991 through the use of emergency rules in accordance with the provisions of Section 5.02 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the adoption of rules to implement the

amendatory changes to this Section made by this amendatory Act of 1991 shall be deemed an emergency and necessary for the public interest, safety and welfare.

(d) No later than January 1, 2001, the Department of Public Aid shall file with the Joint Committee on Administrative Rules, pursuant to the Illinois Administrative Procedure Act, a proposed rule, or a proposed amendment to an existing rule, regarding payment for appropriate services, including assessment, care planning, discharge planning, and treatment provided by nursing facilities to residents who have a serious mental illness.

(Source: P.A. 95-331, eff. 8-21-07; 96-1123, eff. 1-1-11.)

(305 ILCS 5/5-5.5a) (from Ch. 23, par. 5-5.5a)

Sec. 5-5.5a. Kosher kitchen and food service.

(a) The Department of Healthcare and Family Services may develop in its rate structure for ~~skilled~~ nursing facilities ~~and intermediate care facilities~~ an accommodation for fully kosher kitchen and food service operations, rabbinically approved or certified on an annual basis for a facility in which the only kitchen or all kitchens are fully kosher (a fully kosher facility). Beginning in the fiscal year after the fiscal year when this amendatory Act of 1990 becomes effective, the rate structure may provide for an additional payment to such facility not to exceed 50 cents per resident per day if 60% or more of the residents in the facility request kosher

foods or food products prepared in accordance with Jewish religious dietary requirements for religious purposes in a fully kosher facility. Based upon food cost reports of the Illinois Department of Agriculture regarding kosher and non-kosher food available in the various regions of the State, this rate structure may be periodically adjusted by the Department but may not exceed the maximum authorized under this subsection (a).

(b) The Department shall by rule determine how a facility with a fully kosher kitchen and food service may be determined to be eligible and apply for the rate accommodation specified in subsection (a).

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/5-5.6b) (from Ch. 23, par. 5-5.6b)

Sec. 5-5.6b. Prohibition against double payment. If any resident of a ~~skilled~~ nursing facility or ICF/DD ~~intermediate care facility~~ is admitted to such facility on the basis that the charges for such resident's care will be paid from private funds, and the source of payment for such care thereafter changes from private funds to payments under this Article, the facility shall, upon receiving the first such payment under this Article, notify the Illinois Department of such source of private funds for such recipient and repay to the source of private funds any amounts received from such source as payment for care for which payment also was made under this Article.

Private funds shall not include third party resources such as insurance or Medicare benefits or payments made by responsible relatives.

(Source: P.A. 85-824.)

(305 ILCS 5/5-5.7) (from Ch. 23, par. 5-5.7)

Sec. 5-5.7. Cost Reports - Audits. The Department of Healthcare and Family Services shall work with the Department of Public Health to use cost report information currently being collected under provisions of the Nursing Home Care Act and the MR/DD Community Care Act. The Department of Healthcare and Family Services may, in conjunction with the Department of Public Health, develop in accordance with generally accepted accounting principles a uniform chart of accounts which each facility providing services under the medical assistance program shall adopt, after a reasonable period.

Nursing homes licensed under the Nursing Home Care Act or the MR/DD Community Care Act and providers of adult developmental training services certified by the Department of Human Services pursuant to Section 15.2 of the Mental Health and Developmental Disabilities Administrative Act which provide services to clients eligible for medical assistance under this Article are responsible for submitting the required annual cost report to the Department of Healthcare and Family Services.

The Department of Healthcare and Family Services shall

audit the financial and statistical records of each provider participating in the medical assistance program as a ~~skilled~~ nursing facility or ICF/DD ~~or intermediate care facility~~ over a 3 year period, beginning with the close of the first cost reporting year. Following the end of this 3-year term, audits of the financial and statistical records will be performed each year in at least 20% of the facilities participating in the medical assistance program with at least 10% being selected on a random sample basis, and the remainder selected on the basis of exceptional profiles. All audits shall be conducted in accordance with generally accepted auditing standards.

The Department of Healthcare and Family Services shall establish prospective payment rates for categories of service needed within the ~~skilled~~ nursing facility or ICF/DD ~~and intermediate care~~ levels of services, in order to more appropriately recognize the individual needs of patients in nursing facilities.

The Department of Healthcare and Family Services shall provide, during the process of establishing the payment rate for ~~skilled~~ nursing facility or ICF/DD ~~and intermediate care~~ services, or when a substantial change in rates is proposed, an opportunity for public review and comment on the proposed rates prior to their becoming effective.

(Source: P.A. 95-331, eff. 8-21-07; 96-339, eff. 7-1-10.)

(305 ILCS 5/5-5.8b) (from Ch. 23, par. 5-5.8b)

Sec. 5-5.8b. Payment to Campus Facilities. There is hereby established a separate payment category for campus facilities. A "campus facility" is defined as an entity which consists of a long term care facility (or group of facilities if the facilities are on the same contiguous parcel of real estate) which meets all of the following criteria as of May 1, 1987: the entity provides care for both children and adults; residents of the entity reside in three or more separate buildings with congregate and small group living arrangements on a single campus; the entity provides three or more separate licensed levels of care; the entity (or a part of the entity) is enrolled with the Department of ~~Public Aid (now Department of~~ Healthcare and Family Services~~)~~ as a provider of long term care services and receives payments from that Department; the entity (or a part of the entity) receives funding from the Department of ~~Mental Health and Developmental Disabilities (now the Department of~~ Human Services~~)~~; and the entity (or a part of the entity) holds a current license as a child care institution issued by the Department of Children and Family Services.

The Department of Healthcare and Family Services, the Department of Human Services, and the Department of Children and Family Services shall develop jointly a rate methodology or methodologies for campus facilities. Such methodology or methodologies may establish a single rate to be paid by all the agencies, or a separate rate to be paid by each agency, or

separate components to be paid to different parts of the campus facility. All campus facilities shall receive the same rate of payment for similar services. Any methodology developed pursuant to this section shall take into account the actual costs to the facility of providing services to residents, and shall be adequate to reimburse the allowable costs of a campus facility which is economically and efficiently operated. Any methodology shall be established on the basis of historical, financial, and statistical data submitted by campus facilities, and shall take into account the actual costs incurred by campus facilities in providing services, and in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the United States Department of Health and Human Services. Rates may be established on a prospective or retrospective basis. Any methodology shall provide reimbursement for appropriate payment elements, including the following: standard services, patient services, real estate taxes, and capital costs.

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

(Section scheduled to be repealed on July 1, 2013)

Sec. 5A-2. Assessment.

(a) Subject to Sections 5A-3 and 5A-10, an annual assessment on inpatient services is imposed on each hospital

provider in an amount equal to the hospital's occupied bed days multiplied by $84.19 multiplied by the proration factor for State fiscal year 2004 and the hospital's occupied bed days multiplied by $84.19 for State fiscal year 2005.

For State fiscal years 2004 and 2005, the Department of Healthcare and Family Services shall use the number of occupied bed days as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals or if there are data errors in the reported sum of a hospital's occupied bed days as determined by the Department of Healthcare and Family Services (formerly Department of Public Aid), then the Department of Healthcare and Family Services may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department of Healthcare and Family Services or its duly authorized agents and employees.

Subject to Sections 5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007, and 2008, in an amount equal to 2.5835% of the hospital provider's adjusted gross hospital revenue for inpatient services and

2.5835% of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Illinois Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2014 ~~2013~~, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days.

For State fiscal years 2009 through 2014 ~~2013~~, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times

during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(b) (Blank).

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized, during this 94th General Assembly, to adopt rules to reduce the rate of any annual assessment imposed under this Section, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department

of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 94-242, eff. 7-18-05; 94-838, eff. 6-6-06; 95-859, eff. 8-19-08.)

(305 ILCS 5/5A-3) (from Ch. 23, par. 5A-3)

Sec. 5A-3. Exemptions.

(a) (Blank).

(b) A hospital provider that is a State agency, a State university, or a county with a population of 3,000,000 or more is exempt from the assessment imposed by Section 5A-2.

(b-2) A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit is exempt from the assessment imposed by Section 5A-2.

(b-5) (Blank).

(b-10) For State fiscal years 2004 through 2014 ~~2013~~, a hospital provider, described in Section 1903(w)(3)(F) of the Social Security Act, whose hospital does not charge for its services is exempt from the assessment imposed by Section 5A-2,

unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

(b-15) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

(b-20) For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

(b-25) For State fiscal years 2004 and 2005, a hospital provider whose hospital (i) is not a psychiatric hospital, rehabilitation hospital, or children's hospital and (ii) has an average length of inpatient stay greater than 25 days is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

(c) (Blank).

(Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

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

Sec. 5A-5. Notice; penalty; maintenance of records.

(a) The Department of Healthcare and Family Services shall send a notice of assessment to every hospital provider subject to assessment under this Article. The notice of assessment shall notify the hospital of its assessment and shall be sent after receipt by the Department of notification from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services that the payment methodologies required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, and, if necessary, the waiver granted under 42 CFR 433.68 have been approved. The notice shall be on a form prepared by the Illinois Department and shall state the following:

(1) The name of the hospital provider.

(2) The address of the hospital provider's principal place of business from which the provider engages in the occupation of hospital provider in this State, and the name and address of each hospital operated, conducted, or maintained by the provider in this State.

(3) The occupied bed days, occupied bed days less Medicare days, or adjusted gross hospital revenue of the hospital provider (whichever is applicable), the amount of assessment imposed under Section 5A-2 for the State fiscal

year for which the notice is sent, and the amount of each installment to be paid during the State fiscal year.

(4) (Blank).

(5) Other reasonable information as determined by the Illinois Department.

(b) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, the provider shall pay the assessment for each hospital separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to conduct, operate, or maintain a hospital in respect of which the person is subject to assessment under this Article as a hospital provider, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under Section 5A-2 by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate, or maintain a hospital, the person shall pay the assessment for the year as so adjusted (to the extent not previously paid).

(d) Notwithstanding any other provision in this Article, a provider who commences conducting, operating, or maintaining a hospital, upon notice by the Illinois Department, shall pay the assessment computed under Section 5A-2 and subsection (e) in installments on the due dates stated in the notice and on the

regular installment due dates for the State fiscal year occurring after the due dates of the initial notice.

(e) Notwithstanding any other provision in this Article, for State fiscal years 2004 and 2005, in the case of a hospital provider that did not conduct, operate, or maintain a hospital throughout calendar year 2001, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for State fiscal years 2006 through 2008, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2003, the assessment for that State fiscal year shall be computed on the basis of hypothetical adjusted gross hospital revenue for the hospital's first full fiscal year as determined by the Illinois Department (which may be based on annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior provider of the same hospital during the year). Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2014 ~~2013~~, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department.

(f) Every hospital provider subject to assessment under

this Article shall keep sufficient records to permit the determination of adjusted gross hospital revenue for the hospital's fiscal year. All such records shall be kept in the English language and shall, at all times during regular business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(g) The Illinois Department may, by rule, provide a hospital provider a reasonable opportunity to request a clarification or correction of any clerical or computational errors contained in the calculation of its assessment, but such corrections shall not extend to updating the cost report information used to calculate the assessment.

(h) (Blank).

(Source: P.A. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07; 95-859, eff. 8-19-08.)

(305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

Sec. 5A-8. Hospital Provider Fund.

(a) There is created in the State Treasury the Hospital Provider Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving moneys in accordance with Section 5A-6 and disbursing moneys only for the following purposes, notwithstanding any other provision of

law:

(1) For making payments to hospitals as required under Articles V, V-A, VI, and XIV of this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.

(2) For the reimbursement of moneys collected by the Illinois Department from hospitals or hospital providers through error or mistake in performing the activities authorized under this Article and Article V of this Code.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing the activities authorized by this Article.

(4) For payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant.

(5) For making transfers, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers to any other fund in the State treasury, but transfers made under this paragraph (6) shall not exceed the amount transferred previously from that

other fund into the Hospital Provider Fund.

(6.5) For making transfers to the Healthcare Provider Relief Fund, except that transfers made under this paragraph (6.5) shall not exceed $60,000,000 in the aggregate.

(7) For State fiscal years 2004 and 2005 for making transfers to the Health and Human Services Medicaid Trust Fund, including 20% of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. For State fiscal year 2006 for making transfers to the Health and Human Services Medicaid Trust Fund of up to $130,000,000 per year of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.5) For State fiscal year 2007 for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services
Medicaid Trust Fund $20,000,000
Long-Term Care Provider Fund $30,000,000

General Revenue Fund .... $80,000,000.

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.8) For State fiscal year 2008, for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services

Medicaid Trust Fund $40,000,000

Long-Term Care Provider Fund $60,000,000

General Revenue Fund .... $160,000,000.

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.9) For State fiscal years 2009 through 2014 ~~2013~~, for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services

Medicaid Trust Fund $20,000,000

Long Term Care Provider Fund $30,000,000

General Revenue Fund .... $80,000,000.

Except as provided under this paragraph, transfers under this paragraph shall be made within 7 business days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4. For State fiscal year 2009, transfers to the General Revenue Fund under this paragraph shall be made on or before June 30, 2009, as sufficient funds become available in the Hospital Provider Fund to both make the transfers and continue hospital payments.

(8) For making refunds to hospital providers pursuant to Section 5A-10.

Disbursements from the Fund, other than transfers authorized under paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the hospital provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department that are attributable to moneys deposited in the Fund.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) Moneys transferred from another fund in the State treasury.

(5) All other moneys received for the Fund from any other source, including interest earned thereon.

(d) (Blank).

(Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3, eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09.)

(305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

Sec. 5A-10. Applicability.

(a) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The sum of the appropriations for State fiscal years 2004 and 2005 from the General Revenue Fund for hospital payments under the medical assistance program is less than $4,500,000,000 or the appropriation for each of State fiscal years 2006, 2007 and 2008 from the General Revenue Fund for hospital payments under the medical assistance program is less than $2,500,000,000 increased annually to reflect any increase in the number of recipients, or the annual appropriation for State fiscal years 2009 through 2014 ~~2013~~, from the General Revenue Fund

combined with the Hospital Provider Fund as authorized in Section 5A-8 for hospital payments under the medical assistance program, is less than the amount appropriated for State fiscal year 2009, adjusted annually to reflect any change in the number of recipients, excluding State fiscal year 2009 supplemental appropriations made necessary by the enactment of the American Recovery and Reinvestment Act of 2009; or

(2) For State fiscal years prior to State fiscal year 2009, the Department of Healthcare and Family Services (formerly Department of Public Aid) makes changes in its rules that reduce the hospital inpatient or outpatient payment rates, including adjustment payment rates, in effect on October 1, 2004, except for hospitals described in subsection (b) of Section 5A-3 and except for changes in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, so long as those changes do not reduce aggregate expenditures below the amount expended in State fiscal year 2005 for such services; or

(2.1) For State fiscal years 2009 through <u>2014</u> ~~2013~~, the Department of Healthcare and Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008

except for:

(A) any changes for hospitals described in subsection (b) of Section 5A-3; or

(B) any rates for payments made under this Article V-A; or

(C) any changes proposed in State plan amendment transmittal numbers 08-01, 08-02, 08-04, 08-06, and 08-07; or

(D) in relation to any admissions on or after January 1, 2011, a modification in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, for hospitals reimbursed under the diagnosis-related grouping methodology; provided that the Department shall be limited to one such modification during the 36-month period after the effective date of this amendatory Act of the 96th General Assembly; or

(3) The payments to hospitals required under Section 5A-12 or Section 5A-12.2 are changed or are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act.

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be

disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08; 96-8, eff. 4-28-09.)

(305 ILCS 5/5A-14)

Sec. 5A-14. Repeal of assessments and disbursements.

(a) Section 5A-2 is repealed on July 1, 2014 ~~2013~~.

(b) Section 5A-12 is repealed on July 1, 2005.

(c) Section 5A-12.1 is repealed on July 1, 2008.

(d) Section 5A-12.2 is repealed on July 1, 2014 ~~2013~~.

(e) Section 5A-12.3 is repealed on July 1, 2011.

(Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

(305 ILCS 5/5B-1) (from Ch. 23, par. 5B-1)

Sec. 5B-1. Definitions. As used in this Article, unless the context requires otherwise:

"Fund" means the Long-Term Care Provider Fund.

"Long-term care facility" means (i) a ~~skilled~~ nursing ~~or intermediate long term care~~ facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act or the MR/DD Community

Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and (ii) a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long-term care facility" does not include a facility operated by a State agency, a facility participating in the Illinois Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, or operated solely as an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.

"Long-term care provider" means (i) a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility or (ii) a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court. "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital.

"Occupied bed days" shall be computed separately for each long-term care facility operated or maintained by a long-term care provider, and means the sum for all beds of the number of days during the month ~~year~~ on which each bed was ~~is~~ occupied by a resident, other than a resident for whom Medicare Part A is the primary payer ~~(other than a resident receiving care at an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act)~~.

~~"Intergovernmental transfer payment" means the payments established under Section 15-3 of this Code, and includes without limitation payments payable under that Section for July, August, and September of 1992.~~

(Source: P.A. 96-339, eff. 7-1-10.)

(305 ILCS 5/5B-2) (from Ch. 23, par. 5B-2)

Sec. 5B-2. Assessment; no local authorization to tax.

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 an assessment is imposed upon each long-term care provider in an amount equal to $6.07 times the number of occupied bed days due and payable each month ~~for the State fiscal year beginning on July 1, 1992 and ending on June 30, 1993, in an amount equal to $6.30 times the number of occupied bed days for the most recent calendar year ending before the beginning of that State fiscal year~~. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but may not be

added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-state medical care program~~, except those individuals receiving Medicare Part B benefits solely~~.

(b) Nothing in this amendatory Act of 1992 shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon long-term care providers or the occupation of long-term care provider, or a tax or assessment measured by the income or earnings or occupied bed days of a long-term care provider.

(Source: P.A. 87-861.)

(305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

Sec. 5B-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5B-2 ~~for a State fiscal year~~ shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department ~~in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and June 30 of the year~~.

The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

(a-5) Each assessment payment shall be accompanied by an assessment report to be completed by the long-term care provider. A separate report shall be completed for each long-term care facility in this State operated by a long-term care provider. The report shall be in a form and manner prescribed by the Illinois Department and shall at a minimum provide for the reporting of the number of occupied bed days of the long-term care facility for the reporting period and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

(b) The Illinois Department is authorized to establish delayed payment schedules for long-term care providers that are unable to make assessment ~~installment~~ payments when due under this Section due to financial difficulties, as determined by the Illinois Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under

this Article if the long-term care provider has not been paid for services provided during the month on which the assessment is levied.

(c) If a long-term care provider fails to pay the full amount of an assessment payment ~~installment~~ when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 ~~for the State fiscal year~~ a penalty assessment equal to the lesser of (i) 5% of the amount of the assessment payment ~~installment~~ not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment ~~installment~~ amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment ~~installment~~ amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments ~~installments~~. Payment cycles of longer than 60 days shall be one factor the Director takes into account in granting a waiver under this Section.

(c-5) If a long-term care provider fails to file its report with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(d) Nothing in this amendatory Act of 1993 shall be construed to prevent the Illinois Department from collecting

all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

(e) Nothing in this amendatory Act of the 96th General Assembly shall be construed to prevent the Illinois Department from collecting all amounts due under this Code pursuant to an assessment, tax, fee, or penalty imposed before the effective date of this amendatory Act of the 96th General Assembly.

(Source: P.A. 96-444, eff. 8-14-09.)

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

Sec. 5B-5. Annual reporting ~~Reporting~~; penalty; maintenance of records.

(a) After December 31 of each year, and on or before March 31 of the succeeding year, every long-term care provider subject to assessment under this Article shall file a report ~~return~~ with the Illinois Department. ~~The return shall report the occupied bed days for the calendar year just ended and shall be utilized by the Illinois Department to calculate the assessment for the State fiscal year commencing on the next July 1, except that the return for the State fiscal year commencing July 1, 1992 and the report of occupied bed days for calendar year 1991 shall be filed on or before September 30, 1992.~~ The report ~~return~~ shall be in a form and manner prescribed ~~on a form prepared~~ by the Illinois Department and shall state the revenue received by the long-term care

provider, reported in such categories as may be required by the Illinois Department, and other ~~the following:~~

~~(1) The name of the long-term care provider.~~

~~(2) The address of the long-term care provider's principal place of business from which the provider engages in the occupation of long-term care provider in this State, and the name and address of each long-term care facility operated or maintained by the provider in this State.~~

~~(3) The number of occupied bed days of the long-term care provider for the calendar year just ended, the amount of assessment imposed under Section 5B-2 for the State fiscal year for which the return is filed, and the amount of each quarterly installment to be paid during the State fiscal year.~~

~~(4) The amount of penalty due, if any.~~

~~(5) Other~~ reasonable information the Illinois Department requires for the administration of its responsibilities under this Code.

(b) If a long-term care provider operates or maintains more than one long-term care facility in this State, the provider may not file a single return covering all those long-term care facilities, but shall file a separate return for each long-term care facility and shall compute and pay the assessment for each long-term care facility separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to operate or maintain a

long-term care facility in respect of which the person is subject to assessment under this Article as a long-term care provider, the ~~assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under Section 5B-2 by a fraction, the numerator of which is the number of months in the year during which the provider operates or maintains the long-term care facility and the denominator of which is 12. The~~ person shall file a final, amended return with the Illinois Department not more than 90 days after the cessation reflecting the adjustment and shall pay with the final return the assessment for the year as so adjusted (to the extent not previously paid). If a person fails to file a final amended return on a timely basis, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(d) Notwithstanding any other provision of this Article, a provider who commences operating or maintaining a long-term care facility that was under a prior ownership and remained licensed by the Department of Public Health shall notify the Illinois Department of the change in ownership and shall be responsible to immediately pay any prior amounts owed by the facility. ~~shall file an initial return for the State fiscal year in which the commencement occurs within 90 days thereafter and shall pay the assessment computed under Section 5B-2 and subsection (e) in equal installments on the due date of the~~

~~return and on the regular installment due dates for the State fiscal year occurring after the due date of the initial return.~~

(e) <u>The Department shall develop a procedure for sharing with a potential buyer of a facility information regarding outstanding assessments and penalties owed by that facility.</u> ~~Notwithstanding any other provision of this Article, in the case of a long-term care provider that did not operate or maintain a long-term care facility throughout the calendar year preceding a State fiscal year, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by rules adopted by the Illinois Department (which may be based on annualization of the provider's actual occupied bed days for a portion of the calendar year, or the occupied bed days of a comparable facility for the year, including the same facility while operated by a prior provider).~~

(f) In the case of a long-term care provider existing as a corporation or legal entity other than an individual, the return filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

(g) If a long-term care provider fails to file its return ~~for a State fiscal year~~ on or before the due date of the return, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 ~~for the State fiscal year~~ a penalty assessment

equal to 25% of the assessment imposed for the year.

(h) Every long-term care provider subject to assessment under this Article shall keep records and books that will permit the determination of occupied bed days on a calendar year basis. All such books and records shall be kept in the English language and shall, at all times during business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(Source: P.A. 87-861.)

(305 ILCS 5/5B-8) (from Ch. 23, par. 5B-8)

Sec. 5B-8. Long-Term Care Provider Fund.

(a) There is created in the State Treasury the Long-Term Care Provider Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Article. Disbursements from the Fund shall be made only as follows:

(1) For payments to ~~skilled or intermediate~~ nursing facilities, including county nursing facilities but excluding State-operated facilities, under Title XIX of the Social Security Act and Article V of this Code.

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake~~, and for~~

~~making required payments under Section 5-4.38(a)(1) if there are no moneys available for such payments in the Medicaid Long Term Care Provider Participation Fee Trust Fund~~.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing the activities authorized by this Article.

(3.5) For reimbursement of expenses incurred by long-term care facilities, and payment of administrative expenses incurred by the Department of Public Health, in relation to the conduct and analysis of background checks for identified offenders under the Nursing Home Care Act.

(4) For payments of any amounts that are reimbursable to the federal government for payments from this Fund that are required to be paid by State warrant.

(5) For making transfers to the General Obligation Bond Retirement and Interest Fund, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

<u>(6) For making transfers, at the direction of the Director of the Governor's Office of Management and Budget during each fiscal year beginning on or after July 1, 2011, to other State funds in an annual amount of $20,000,000 of</u>

the tax collected pursuant to this Article for the purpose of enforcement of nursing home standards, support of the ombudsman program, and efforts to expand home and community-based services.

Disbursements from the Fund, other than transfers made pursuant to paragraphs (5) and (6) of this subsection ~~to the General Obligation Bond Retirement and Interest Fund~~, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the long-term care provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department that are attributable to moneys deposited in the Fund.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) (Blank). ~~Any balance in the Medicaid Long Term Care Provider Participation Fee Fund in the State Treasury. The balance shall be transferred to the Fund upon certification by the Illinois Department to the State Comptroller that all of the disbursements required by Section 5-4.31(b) of this Code have been made.~~

(5) All other monies received for the Fund from any other source, including interest earned thereon.

(Source: P.A. 95-707, eff. 1-11-08.)

(305 ILCS 5/5-4.20 rep.)

(305 ILCS 5/5-4.21 rep.)

(305 ILCS 5/5-4.22 rep.)

(305 ILCS 5/5-4.23 rep.)

(305 ILCS 5/5-4.24 rep.)

(305 ILCS 5/5-4.25 rep.)

(305 ILCS 5/5-4.26 rep.)

(305 ILCS 5/5-4.27 rep.)

(305 ILCS 5/5-4.28 rep.)

(305 ILCS 5/5-4.29 rep.)

(305 ILCS 5/5-4.30 rep.)

(305 ILCS 5/5-4.31 rep.)

(305 ILCS 5/5-4.32 rep.)

(305 ILCS 5/5-4.33 rep.)

(305 ILCS 5/5-4.34 rep.)

(305 ILCS 5/5-4.35 rep.)

(305 ILCS 5/5-4.36 rep.)

(305 ILCS 5/5-4.37 rep.)

(305 ILCS 5/5-4.38 rep.)

(305 ILCS 5/5-4.39 rep.)

(305 ILCS 5/5-5.6a rep.)

(305 ILCS 5/5-5.11 rep.)

(305 ILCS 5/5-5.21 rep.)

Section 35. The Illinois Public Aid Code is amended by repealing Sections 5-4.20, 5-4.21, 5-4.22, 5-4.23, 5-4.24, 5-4.25, 5-4.26, 5-4.27, 5-4.28, 5-4.29, 5-4.30, 5-4.31, 5-4.32, 5-4.33, 5-4.34, 5-4.35, 5-4.36, 5-4.37, 5-4.38, 5-4.39, 5-5.6a, 5-5.11, and 5-5.21.

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