AN ACT concerning health.

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

Section 5. The Illinois Administrative Procedure Act is amended by changing Section 5-45 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare.

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's

finding and a statement of the specific reasons for the finding shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the persons who may be affected by them.

(c) An emergency rule may be effective for a period of not longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24-month period, except that this limitation on the number of emergency rules that may be adopted in a 24-month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, (iii) emergency rules adopted by the Illinois Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health, (iv) emergency rules adopted pursuant to subsection (n) of this Section, (v) emergency rules adopted pursuant to subsection (o) of this Section, or (vi) emergency rules adopted pursuant to subsection (c-5) of this Section. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

(c-5) To facilitate the maintenance of the program of group health benefits provided to annuitants, survivors, and retired employees under the State Employees Group Insurance Act of 1971, rules to alter the contributions to be paid by the State, annuitants, survivors, retired employees, or any combination of those entities, for that program of group health benefits, shall be adopted as emergency rules. The adoption of those rules shall be considered an emergency and necessary for the public interest, safety, and welfare.

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

(e) In order to provide for the expeditious and timely implementation of the State's fiscal year 2000 budget, emergency rules to implement any provision of Public Act 91-24 or any other budget initiative for fiscal year 2000 may be adopted in accordance with this Section by the agency charged

with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (e). The adoption of emergency rules authorized by this subsection (e) shall be deemed to be necessary for the public interest, safety, and welfare.

(f) In order to provide for the expeditious and timely implementation of the State's fiscal year 2001 budget, emergency rules to implement any provision of Public Act 91-712 or any other budget initiative for fiscal year 2001 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (f). The adoption of emergency rules authorized by this subsection (f) shall be deemed to be necessary for the public interest, safety, and welfare.

(g) In order to provide for the expeditious and timely implementation of the State's fiscal year 2002 budget, emergency rules to implement any provision of Public Act 92-10 or any other budget initiative for fiscal year 2002 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and

the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

(h) In order to provide for the expeditious and timely implementation of the State's fiscal year 2003 budget, emergency rules to implement any provision of Public Act 92-597 or any other budget initiative for fiscal year 2003 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (h). The adoption of emergency rules authorized by this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

(i) In order to provide for the expeditious and timely implementation of the State's fiscal year 2004 budget, emergency rules to implement any provision of Public Act 93-20 or any other budget initiative for fiscal year 2004 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (i). The adoption of

emergency rules authorized by this subsection (i) shall be deemed to be necessary for the public interest, safety, and welfare.

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of Public Act 94-48 or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption

of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family Services may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Persons with Disabilities Property Tax Relief Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act (now the Illinois Prescription Drug Discount Program Act), and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including rules effective July 1, 2007, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

(m) In order to provide for the expeditious and timely

implementation of the provisions of the State's fiscal year 2008 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2008, including rules effective July 1, 2008, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (m) shall be deemed to be necessary for the public interest, safety, and welfare.

(n) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2010 budget, emergency rules to implement any provision of Public Act 96-45 or any other budget initiative authorized by the 96th General Assembly for fiscal year 2010 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (n) shall be deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (n) shall apply only to rules promulgated during Fiscal Year 2010.

(o) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year

2011 budget, emergency rules to implement any provision of Public Act 96-958 or any other budget initiative authorized by the 96th General Assembly for fiscal year 2011 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (o) is deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (o) applies only to rules promulgated on or after July 1, 2010 (the effective date of Public Act 96-958) through June 30, 2011.

(p) In order to provide for the expeditious and timely implementation of the provisions of Public Act 97-689, emergency rules to implement any provision of Public Act 97-689 may be adopted in accordance with this subsection (p) by the agency charged with administering that provision or initiative. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection (p), and the effective period may continue through June 30, 2013. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (p). The adoption of emergency rules authorized by this subsection (p) is deemed to be necessary for the public interest, safety, and welfare.

(q) In order to provide for the expeditious and timely implementation of the provisions of Articles 7, 8, 9, 11, and 12 of Public Act 98-104, emergency rules to implement any

provision of Articles 7, 8, 9, 11, and 12 of Public Act 98-104 may be adopted in accordance with this subsection (q) by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (q). The adoption of emergency rules authorized by this subsection (q) is deemed to be necessary for the public interest, safety, and welfare.

(r) In order to provide for the expeditious and timely implementation of the provisions of Public Act 98-651, emergency rules to implement Public Act 98-651 may be adopted in accordance with this subsection (r) by the Department of Healthcare and Family Services. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (r). The adoption of emergency rules authorized by this subsection (r) is deemed to be necessary for the public interest, safety, and welfare.

(s) In order to provide for the expeditious and timely implementation of the provisions of Sections 5-5b.1 and 5A-2 of the Illinois Public Aid Code, emergency rules to implement any provision of Section 5-5b.1 or Section 5A-2 of the Illinois Public Aid Code may be adopted in accordance with this subsection (s) by the Department of Healthcare and Family Services. The rulemaking authority granted in this subsection (s) shall apply only to those rules adopted prior to July 1, 2015. Notwithstanding any other provision of this Section, any

emergency rule adopted under this subsection (s) shall only apply to payments made for State fiscal year 2015. The adoption of emergency rules authorized by this subsection (s) is deemed to be necessary for the public interest, safety, and welfare.

(t) In order to provide for the expeditious and timely implementation of the provisions of Article II of Public Act 99-6, emergency rules to implement the changes made by Article II of Public Act 99-6 to the Emergency Telephone System Act may be adopted in accordance with this subsection (t) by the Department of State Police. The rulemaking authority granted in this subsection (t) shall apply only to those rules adopted prior to July 1, 2016. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (t). The adoption of emergency rules authorized by this subsection (t) is deemed to be necessary for the public interest, safety, and welfare.

(u) In order to provide for the expeditious and timely implementation of the provisions of the Burn Victims Relief Act, emergency rules to implement any provision of the Act may be adopted in accordance with this subsection (u) by the Department of Insurance. The rulemaking authority granted in this subsection (u) shall apply only to those rules adopted prior to December 31, 2015. The adoption of emergency rules authorized by this subsection (u) is deemed to be necessary for the public interest, safety, and welfare.

(v) In order to provide for the expeditious and timely

implementation of the provisions of Public Act 99-516, emergency rules to implement Public Act 99-516 may be adopted in accordance with this subsection (v) by the Department of Healthcare and Family Services. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (v). The adoption of emergency rules authorized by this subsection (v) is deemed to be necessary for the public interest, safety, and welfare.

(w) In order to provide for the expeditious and timely implementation of the provisions of Public Act 99-796, emergency rules to implement the changes made by Public Act 99-796 may be adopted in accordance with this subsection (w) by the Adjutant General. The adoption of emergency rules authorized by this subsection (w) is deemed to be necessary for the public interest, safety, and welfare.

(x) In order to provide for the expeditious and timely implementation of the provisions of Public Act 99-906, emergency rules to implement subsection (i) of Section 16-115D, subsection (g) of Section 16-128A, and subsection (a) of Section 16-128B of the Public Utilities Act may be adopted in accordance with this subsection (x) by the Illinois Commerce Commission. The rulemaking authority granted in this subsection (x) shall apply only to those rules adopted within 180 days after June 1, 2017 (the effective date of Public Act 99-906). The adoption of emergency rules authorized by this subsection (x) is deemed to be necessary for the public

interest, safety, and welfare.

(y) In order to provide for the expeditious and timely implementation of the provisions of Public Act 100-23 ~~this amendatory Act of the 100th General Assembly~~, emergency rules to implement the changes made by Public Act 100-23 ~~this amendatory Act of the 100th General Assembly~~ to Section 4.02 of the Illinois Act on the Aging, Sections 5.5.4 and 5-5.4i of the Illinois Public Aid Code, Section 55-30 of the Alcoholism and Other Drug Abuse and Dependency Act, and Sections 74 and 75 of the Mental Health and Developmental Disabilities Administrative Act may be adopted in accordance with this subsection (y) by the respective Department. The adoption of emergency rules authorized by this subsection (y) is deemed to be necessary for the public interest, safety, and welfare.

(z) In order to provide for the expeditious and timely implementation of the provisions of Public Act 100-554 ~~this amendatory Act of the 100th General Assembly~~, emergency rules to implement the changes made by Public Act 100-554 ~~this amendatory Act of the 100th General Assembly~~ to Section 4.7 of the Lobbyist Registration Act may be adopted in accordance with this subsection (z) by the Secretary of State. The adoption of emergency rules authorized by this subsection (z) is deemed to be necessary for the public interest, safety, and welfare.

(aa) In order to provide for the expeditious and timely initial implementation of the changes made to Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code under the provisions

of Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~, the Department of Healthcare and Family Services may adopt emergency rules in accordance with this subsection (aa). The 24-month limitation on the adoption of emergency rules does not apply to rules to initially implement the changes made to Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code adopted under this subsection (aa). The adoption of emergency rules authorized by this subsection (aa) is deemed to be necessary for the public interest, safety, and welfare.

(bb) In order to provide for the expeditious and timely implementation of the provisions of Public Act 100-587 ~~this amendatory Act of the 100th General Assembly~~, emergency rules to implement the changes made by Public Act 100-587 ~~this amendatory Act of the 100th General Assembly~~ to Section 4.02 of the Illinois Act on the Aging, Sections 5.5.4 and 5-5.4i of the Illinois Public Aid Code, subsection (b) of Section 55-30 of the Alcoholism and Other Drug Abuse and Dependency Act, Section 5-104 of the Specialized Mental Health Rehabilitation Act of 2013, and Section 75 and subsection (b) of Section 74 of the Mental Health and Developmental Disabilities Administrative Act may be adopted in accordance with this subsection (bb) by the respective Department. The adoption of emergency rules authorized by this subsection (bb) is deemed to be necessary for the public interest, safety, and welfare.

(cc) ~~(bb)~~ In order to provide for the expeditious and timely implementation of the provisions of Public Act 100-587

~~this amendatory Act of the 100th General Assembly~~, emergency rules may be adopted in accordance with this subsection (cc) ~~(bb)~~ to implement the changes made by Public Act 100-587 ~~this amendatory Act of the 100th General Assembly~~ to: Sections 14-147.5 and 14-147.6 of the Illinois Pension Code by the Board created under Article 14 of the Code; Sections 15-185.5 and 15-185.6 of the Illinois Pension Code by the Board created under Article 15 of the Code; and Sections 16-190.5 and 16-190.6 of the Illinois Pension Code by the Board created under Article 16 of the Code. The adoption of emergency rules authorized by this subsection (cc) ~~(bb)~~ is deemed to be necessary for the public interest, safety, and welfare.

(dd) ~~(aa)~~ In order to provide for the expeditious and timely implementation of the provisions of Public Act 100-864 ~~this amendatory Act of the 100th General Assembly~~, emergency rules to implement the changes made by Public Act 100-864 ~~this amendatory Act of the 100th General Assembly~~ to Section 3.35 of the Newborn Metabolic Screening Act may be adopted in accordance with this subsection (dd) ~~(aa)~~ by the Secretary of State. The adoption of emergency rules authorized by this subsection (dd) ~~(aa)~~ is deemed to be necessary for the public interest, safety, and welfare.

(ee) In order to provide for the expeditious and timely initial implementation of the changes made to Articles 5A and 14 of the Illinois Public Aid Code under the provisions of this amendatory Act of the 100th General Assembly, the Department of

Healthcare and Family Services may on a one-time-only basis adopt emergency rules in accordance with this subsection (ee). The 24-month limitation on the adoption of emergency rules does not apply to rules to initially implement the changes made to Articles 5A and 14 of the Illinois Public Aid Code adopted under this subsection (ee). The adoption of emergency rules authorized by this subsection (ee) is deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 99-2, eff. 3-26-15; 99-6, eff. 1-1-16; 99-143, eff. 7-27-15; 99-455, eff. 1-1-16; 99-516, eff. 6-30-16; 99-642, eff. 7-28-16; 99-796, eff. 1-1-17; 99-906, eff. 6-1-17; 100-23, eff. 7-6-17; 100-554, eff. 11-16-17; 100-581, eff. 3-12-18; 100-587, Article 95, Section 95-5, eff. 6-4-18; 100-587, Article 110, Section 110-5, eff. 6-4-18; 100-864, eff. 8-14-18; revised 10-18-18.)

Section 15. The Use Tax Act is amended by changing Section 3-8 as follows:

(35 ILCS 105/3-8)

Sec. 3-8. Hospital exemption.

(a) Until July 1, 2022, tangible ~~Tangible~~ personal property sold to or used by a hospital owner that owns one or more hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act, or a hospital affiliate that is not already exempt under another provision of

this Act and meets the criteria for an exemption under this Section, is exempt from taxation under this Act.

(b) A hospital owner or hospital affiliate satisfies the conditions for an exemption under this Section if the value of qualified services or activities listed in subsection (c) of this Section for the hospital year equals or exceeds the relevant hospital entity's estimated property tax liability, without regard to any property tax exemption granted under Section 15-86 of the Property Tax Code, for the calendar year in which exemption or renewal of exemption is sought. For purposes of making the calculations required by this subsection (b), if the relevant hospital entity is a hospital owner that owns more than one hospital, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities relating to the hospital that includes the subject property, and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to the properties comprising that hospital. In the case of a multi-state hospital system or hospital affiliate, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities that occur in Illinois and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to its property located in Illinois.

(c) The following services and activities shall be

considered for purposes of making the calculations required by subsection (b):

(1) Charity care. Free or discounted services provided pursuant to the relevant hospital entity's financial assistance policy, measured at cost, including discounts provided under the Hospital Uninsured Patient Discount Act.

(2) Health services to low-income and underserved individuals. Other unreimbursed costs of the relevant hospital entity for providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals. Those activities or services may include, but are not limited to: financial or in-kind support to affiliated or unaffiliated hospitals, hospital affiliates, community clinics, or programs that treat low-income or underserved individuals; paying for or subsidizing health care professionals who care for low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals because of their medical condition; and prenatal or childbirth outreach to low-income or underserved persons.

(3) Subsidy of State or local governments. Direct or

indirect financial or in-kind subsidies of State or local governments by the relevant hospital entity that pay for or subsidize activities or programs related to health care for low-income or underserved individuals.

(4) Support for State health care programs for low-income individuals. At the election of the hospital applicant for each applicable year, either (A) 10% of payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program. The amount of subsidy

for purpose of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly.

(5) Dual-eligible subsidy. The amount of subsidy provided to government by treating dual-eligible Medicare/Medicaid patients. The amount of subsidy for purposes of this item (5) is calculated by multiplying the relevant hospital entity's unreimbursed costs for Medicare, calculated in the same manner as determined in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly, by the relevant hospital entity's ratio of dual-eligible patients to total Medicare patients.

(6) Relief of the burden of government related to health care. Except to the extent otherwise taken into account in this subsection, the portion of unreimbursed costs of the relevant hospital entity attributable to providing, paying for, or subsidizing goods, activities, or services that relieve the burden of government related to health care for low-income individuals. Such activities or services shall include, but are not limited to, providing emergency, trauma, burn, neonatal, psychiatric, rehabilitation, or other special services; providing medical education; and conducting medical research or

training of health care professionals. The portion of those unreimbursed costs attributable to benefiting low-income individuals shall be determined using the ratio calculated by adding the relevant hospital entity's costs attributable to charity care, Medicaid, other means-tested government programs, Medicare patients with disabilities under age 65, and dual-eligible Medicare/Medicaid patients and dividing that total by the relevant hospital entity's total costs. Such costs for the numerator and denominator shall be determined by multiplying gross charges by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I). In the case of emergency services, the ratio shall be calculated using costs (gross charges multiplied by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

(7) Any other activity by the relevant hospital entity that the Department determines relieves the burden of government or addresses the health of low-income or underserved individuals.

(d) The hospital applicant shall include information in its exemption application establishing that it satisfies the requirements of subsection (b). For purposes of making the calculations required by subsection (b), the hospital

applicant may for each year elect to use either (1) the value of the services or activities listed in subsection (e) for the hospital year or (2) the average value of those services or activities for the 3 fiscal years ending with the hospital year. If the relevant hospital entity has been in operation for less than 3 completed fiscal years, then the latter calculation, if elected, shall be performed on a pro rata basis.

(e) For purposes of making the calculations required by this Section:

(1) particular services or activities eligible for consideration under any of the paragraphs (1) through (7) of subsection (c) may not be counted under more than one of those paragraphs; and

(2) the amount of unreimbursed costs and the amount of subsidy shall not be reduced by restricted or unrestricted payments received by the relevant hospital entity as contributions deductible under Section 170(a) of the Internal Revenue Code.

(f) (Blank).

(g) Estimation of Exempt Property Tax Liability. The estimated property tax liability used for the determination in subsection (b) shall be calculated as follows:

(1) "Estimated property tax liability" means the estimated dollar amount of property tax that would be owed, with respect to the exempt portion of each of the relevant

hospital entity's properties that are already fully or partially exempt, or for which an exemption in whole or in part is currently being sought, and then aggregated as applicable, as if the exempt portion of those properties were subject to tax, calculated with respect to each such property by multiplying:

(A) the lesser of (i) the actual assessed value, if any, of the portion of the property for which an exemption is sought or (ii) an estimated assessed value of the exempt portion of such property as determined in item (2) of this subsection (g), by

(B) the applicable State equalization rate (yielding the equalized assessed value), by

(C) the applicable tax rate.

(2) The estimated assessed value of the exempt portion of the property equals the sum of (i) the estimated fair market value of buildings on the property, as determined in accordance with subparagraphs (A) and (B) of this item (2), multiplied by the applicable assessment factor, and (ii) the estimated assessed value of the land portion of the property, as determined in accordance with subparagraph (C).

(A) The "estimated fair market value of buildings on the property" means the replacement value of any exempt portion of buildings on the property, minus depreciation, determined utilizing the cost

replacement method whereby the exempt square footage of all such buildings is multiplied by the replacement cost per square foot for Class A Average building found in the most recent edition of the Marshall & Swift Valuation Services Manual, adjusted by any appropriate current cost and local multipliers.

(B) Depreciation, for purposes of calculating the estimated fair market value of buildings on the property, is applied by utilizing a weighted mean life for the buildings based on original construction and assuming a 40-year life for hospital buildings and the applicable life for other types of buildings as specified in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets". In the case of hospital buildings, the remaining life is divided by 40 and this ratio is multiplied by the replacement cost of the buildings to obtain an estimated fair market value of buildings. If a hospital building is older than 35 years, a remaining life of 5 years for residual value is assumed; and if a building is less than 8 years old, a remaining life of 32 years is assumed.

(C) The estimated assessed value of the land portion of the property shall be determined by multiplying (i) the per square foot average of the assessed values of three parcels of land (not including

farm land, and excluding the assessed value of the improvements thereon) reasonably comparable to the property, by (ii) the number of square feet comprising the exempt portion of the property's land square footage.

(3) The assessment factor, State equalization rate, and tax rate (including any special factors such as Enterprise Zones) used in calculating the estimated property tax liability shall be for the most recent year that is publicly available from the applicable chief county assessment officer or officers at least 90 days before the end of the hospital year.

(4) The method utilized to calculate estimated property tax liability for purposes of this Section 15-86 shall not be utilized for the actual valuation, assessment, or taxation of property pursuant to the Property Tax Code.

(h) For the purpose of this Section, the following terms shall have the meanings set forth below:

(1) "Hospital" means any institution, place, building, buildings on a campus, or other health care facility located in Illinois that is licensed under the Hospital Licensing Act and has a hospital owner.

(2) "Hospital owner" means a not-for-profit corporation that is the titleholder of a hospital, or the owner of the beneficial interest in an Illinois land trust that is the titleholder of a hospital.

(3) "Hospital affiliate" means any corporation, partnership, limited partnership, joint venture, limited liability company, association or other organization, other than a hospital owner, that directly or indirectly controls, is controlled by, or is under common control with one or more hospital owners and that supports, is supported by, or acts in furtherance of the exempt health care purposes of at least one of those hospital owners' hospitals.

(4) "Hospital system" means a hospital and one or more other hospitals or hospital affiliates related by common control or ownership.

(5) "Control" relating to hospital owners, hospital affiliates, or hospital systems means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the entity, whether through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

(6) "Hospital applicant" means a hospital owner or hospital affiliate that files an application for an exemption or renewal of exemption under this Section.

(7) "Relevant hospital entity" means (A) the hospital owner, in the case of a hospital applicant that is a hospital owner, and (B) at the election of a hospital applicant that is a hospital affiliate, either (i) the hospital affiliate or (ii) the hospital system to which the

hospital applicant belongs, including any hospitals or hospital affiliates that are related by common control or ownership.

(8) "Subject property" means property used for the calculation under subsection (b) of this Section.

(9) "Hospital year" means the fiscal year of the relevant hospital entity, or the fiscal year of one of the hospital owners in the hospital system if the relevant hospital entity is a hospital system with members with different fiscal years, that ends in the year for which the exemption is sought.

(i) It is the intent of the General Assembly that any exemptions taken, granted, or renewed under this Section prior to the effective date of this amendatory Act of the 100th General Assembly are hereby validated.

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

Section 20. The Service Use Tax Act is amended by changing Section 3-8 as follows:

(35 ILCS 110/3-8)

Sec. 3-8. Hospital exemption.

(a) Until July 1, 2022, tangible ~~Tangible~~ personal property sold to or used by a hospital owner that owns one or more hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act, or a hospital

affiliate that is not already exempt under another provision of this Act and meets the criteria for an exemption under this Section, is exempt from taxation under this Act.

(b) A hospital owner or hospital affiliate satisfies the conditions for an exemption under this Section if the value of qualified services or activities listed in subsection (c) of this Section for the hospital year equals or exceeds the relevant hospital entity's estimated property tax liability, without regard to any property tax exemption granted under Section 15-86 of the Property Tax Code, for the calendar year in which exemption or renewal of exemption is sought. For purposes of making the calculations required by this subsection (b), if the relevant hospital entity is a hospital owner that owns more than one hospital, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities relating to the hospital that includes the subject property, and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to the properties comprising that hospital. In the case of a multi-state hospital system or hospital affiliate, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities that occur in Illinois and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to its property located in Illinois.

(c) The following services and activities shall be considered for purposes of making the calculations required by subsection (b):

(1) Charity care. Free or discounted services provided pursuant to the relevant hospital entity's financial assistance policy, measured at cost, including discounts provided under the Hospital Uninsured Patient Discount Act.

(2) Health services to low-income and underserved individuals. Other unreimbursed costs of the relevant hospital entity for providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals. Those activities or services may include, but are not limited to: financial or in-kind support to affiliated or unaffiliated hospitals, hospital affiliates, community clinics, or programs that treat low-income or underserved individuals; paying for or subsidizing health care professionals who care for low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals because of their medical condition; and prenatal or childbirth outreach to low-income or underserved persons.

(3) Subsidy of State or local governments. Direct or indirect financial or in-kind subsidies of State or local governments by the relevant hospital entity that pay for or subsidize activities or programs related to health care for low-income or underserved individuals.

(4) Support for State health care programs for low-income individuals. At the election of the hospital applicant for each applicable year, either (A) 10% of payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance, the Covering ALL KIDS Health Insurance Act, and the State

Children's Health Insurance Program. The amount of subsidy for purposes of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly.

(5) Dual-eligible subsidy. The amount of subsidy provided to government by treating dual-eligible Medicare/Medicaid patients. The amount of subsidy for purposes of this item (5) is calculated by multiplying the relevant hospital entity's unreimbursed costs for Medicare, calculated in the same manner as determined in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly, by the relevant hospital entity's ratio of dual-eligible patients to total Medicare patients.

(6) Relief of the burden of government related to health care. Except to the extent otherwise taken into account in this subsection, the portion of unreimbursed costs of the relevant hospital entity attributable to providing, paying for, or subsidizing goods, activities, or services that relieve the burden of government related to health care for low-income individuals. Such activities or services shall include, but are not limited to, providing emergency, trauma, burn, neonatal, psychiatric, rehabilitation, or other special services; providing

medical education; and conducting medical research or training of health care professionals. The portion of those unreimbursed costs attributable to benefiting low-income individuals shall be determined using the ratio calculated by adding the relevant hospital entity's costs attributable to charity care, Medicaid, other means-tested government programs, Medicare patients with disabilities under age 65, and dual-eligible Medicare/Medicaid patients and dividing that total by the relevant hospital entity's total costs. Such costs for the numerator and denominator shall be determined by multiplying gross charges by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I). In the case of emergency services, the ratio shall be calculated using costs (gross charges multiplied by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

(7) Any other activity by the relevant hospital entity that the Department determines relieves the burden of government or addresses the health of low-income or underserved individuals.

(d) The hospital applicant shall include information in its exemption application establishing that it satisfies the requirements of subsection (b). For purposes of making the

calculations required by subsection (b), the hospital applicant may for each year elect to use either (1) the value of the services or activities listed in subsection (e) for the hospital year or (2) the average value of those services or activities for the 3 fiscal years ending with the hospital year. If the relevant hospital entity has been in operation for less than 3 completed fiscal years, then the latter calculation, if elected, shall be performed on a pro rata basis.

(e) For purposes of making the calculations required by this Section:

(1) particular services or activities eligible for consideration under any of the paragraphs (1) through (7) of subsection (c) may not be counted under more than one of those paragraphs; and

(2) the amount of unreimbursed costs and the amount of subsidy shall not be reduced by restricted or unrestricted payments received by the relevant hospital entity as contributions deductible under Section 170(a) of the Internal Revenue Code.

(f) (Blank).

(g) Estimation of Exempt Property Tax Liability. The estimated property tax liability used for the determination in subsection (b) shall be calculated as follows:

(1) "Estimated property tax liability" means the estimated dollar amount of property tax that would be owed,

with respect to the exempt portion of each of the relevant hospital entity's properties that are already fully or partially exempt, or for which an exemption in whole or in part is currently being sought, and then aggregated as applicable, as if the exempt portion of those properties were subject to tax, calculated with respect to each such property by multiplying:

(A) the lesser of (i) the actual assessed value, if any, of the portion of the property for which an exemption is sought or (ii) an estimated assessed value of the exempt portion of such property as determined in item (2) of this subsection (g), by

(B) the applicable State equalization rate (yielding the equalized assessed value), by

(C) the applicable tax rate.

(2) The estimated assessed value of the exempt portion of the property equals the sum of (i) the estimated fair market value of buildings on the property, as determined in accordance with subparagraphs (A) and (B) of this item (2), multiplied by the applicable assessment factor, and (ii) the estimated assessed value of the land portion of the property, as determined in accordance with subparagraph (C).

(A) The "estimated fair market value of buildings on the property" means the replacement value of any exempt portion of buildings on the property, minus

depreciation, determined utilizing the cost replacement method whereby the exempt square footage of all such buildings is multiplied by the replacement cost per square foot for Class A Average building found in the most recent edition of the Marshall & Swift Valuation Services Manual, adjusted by any appropriate current cost and local multipliers.

(B) Depreciation, for purposes of calculating the estimated fair market value of buildings on the property, is applied by utilizing a weighted mean life for the buildings based on original construction and assuming a 40-year life for hospital buildings and the applicable life for other types of buildings as specified in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets". In the case of hospital buildings, the remaining life is divided by 40 and this ratio is multiplied by the replacement cost of the buildings to obtain an estimated fair market value of buildings. If a hospital building is older than 35 years, a remaining life of 5 years for residual value is assumed; and if a building is less than 8 years old, a remaining life of 32 years is assumed.

(C) The estimated assessed value of the land portion of the property shall be determined by multiplying (i) the per square foot average of the

assessed values of three parcels of land (not including farm land, and excluding the assessed value of the improvements thereon) reasonably comparable to the property, by (ii) the number of square feet comprising the exempt portion of the property's land square footage.

(3) The assessment factor, State equalization rate, and tax rate (including any special factors such as Enterprise Zones) used in calculating the estimated property tax liability shall be for the most recent year that is publicly available from the applicable chief county assessment officer or officers at least 90 days before the end of the hospital year.

(4) The method utilized to calculate estimated property tax liability for purposes of this Section 15-86 shall not be utilized for the actual valuation, assessment, or taxation of property pursuant to the Property Tax Code.

(h) For the purpose of this Section, the following terms shall have the meanings set forth below:

(1) "Hospital" means any institution, place, building, buildings on a campus, or other health care facility located in Illinois that is licensed under the Hospital Licensing Act and has a hospital owner.

(2) "Hospital owner" means a not-for-profit corporation that is the titleholder of a hospital, or the owner of the beneficial interest in an Illinois land trust

that is the titleholder of a hospital.

(3) "Hospital affiliate" means any corporation, partnership, limited partnership, joint venture, limited liability company, association or other organization, other than a hospital owner, that directly or indirectly controls, is controlled by, or is under common control with one or more hospital owners and that supports, is supported by, or acts in furtherance of the exempt health care purposes of at least one of those hospital owners' hospitals.

(4) "Hospital system" means a hospital and one or more other hospitals or hospital affiliates related by common control or ownership.

(5) "Control" relating to hospital owners, hospital affiliates, or hospital systems means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the entity, whether through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

(6) "Hospital applicant" means a hospital owner or hospital affiliate that files an application for an exemption or renewal of exemption under this Section.

(7) "Relevant hospital entity" means (A) the hospital owner, in the case of a hospital applicant that is a hospital owner, and (B) at the election of a hospital applicant that is a hospital affiliate, either (i) the

hospital affiliate or (ii) the hospital system to which the hospital applicant belongs, including any hospitals or hospital affiliates that are related by common control or ownership.

(8) "Subject property" means property used for the calculation under subsection (b) of this Section.

(9) "Hospital year" means the fiscal year of the relevant hospital entity, or the fiscal year of one of the hospital owners in the hospital system if the relevant hospital entity is a hospital system with members with different fiscal years, that ends in the year for which the exemption is sought.

(i) It is the intent of the General Assembly that any exemptions taken, granted, or renewed under this Section prior to the effective date of this amendatory Act of the 100th General Assembly are hereby validated.

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

Section 25. The Service Occupation Tax Act is amended by changing Section 3-8 as follows:

(35 ILCS 115/3-8)

Sec. 3-8. Hospital exemption.

(a) Until July 1, 2022, tangible ~~Tangible~~ personal property sold to or used by a hospital owner that owns one or more hospitals licensed under the Hospital Licensing Act or operated

under the University of Illinois Hospital Act, or a hospital affiliate that is not already exempt under another provision of this Act and meets the criteria for an exemption under this Section, is exempt from taxation under this Act.

(b) A hospital owner or hospital affiliate satisfies the conditions for an exemption under this Section if the value of qualified services or activities listed in subsection (c) of this Section for the hospital year equals or exceeds the relevant hospital entity's estimated property tax liability, without regard to any property tax exemption granted under Section 15-86 of the Property Tax Code, for the calendar year in which exemption or renewal of exemption is sought. For purposes of making the calculations required by this subsection (b), if the relevant hospital entity is a hospital owner that owns more than one hospital, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities relating to the hospital that includes the subject property, and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to the properties comprising that hospital. In the case of a multi-state hospital system or hospital affiliate, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities that occur in Illinois and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to its property

located in Illinois.

(c) The following services and activities shall be considered for purposes of making the calculations required by subsection (b):

(1) Charity care. Free or discounted services provided pursuant to the relevant hospital entity's financial assistance policy, measured at cost, including discounts provided under the Hospital Uninsured Patient Discount Act.

(2) Health services to low-income and underserved individuals. Other unreimbursed costs of the relevant hospital entity for providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals. Those activities or services may include, but are not limited to: financial or in-kind support to affiliated or unaffiliated hospitals, hospital affiliates, community clinics, or programs that treat low-income or underserved individuals; paying for or subsidizing health care professionals who care for low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals because of their medical condition; and prenatal or

childbirth outreach to low-income or underserved persons.

(3) Subsidy of State or local governments. Direct or indirect financial or in-kind subsidies of State or local governments by the relevant hospital entity that pay for or subsidize activities or programs related to health care for low-income or underserved individuals.

(4) Support for State health care programs for low-income individuals. At the election of the hospital applicant for each applicable year, either (A) 10% of payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance,

the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program. The amount of subsidy for purposes of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly.

(5) Dual-eligible subsidy. The amount of subsidy provided to government by treating dual-eligible Medicare/Medicaid patients. The amount of subsidy for purposes of this item (5) is calculated by multiplying the relevant hospital entity's unreimbursed costs for Medicare, calculated in the same manner as determined in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly, by the relevant hospital entity's ratio of dual-eligible patients to total Medicare patients.

(6) Relief of the burden of government related to health care. Except to the extent otherwise taken into account in this subsection, the portion of unreimbursed costs of the relevant hospital entity attributable to providing, paying for, or subsidizing goods, activities, or services that relieve the burden of government related to health care for low-income individuals. Such activities or services shall include, but are not limited to, providing emergency, trauma, burn, neonatal, psychiatric,

rehabilitation, or other special services; providing medical education; and conducting medical research or training of health care professionals. The portion of those unreimbursed costs attributable to benefiting low-income individuals shall be determined using the ratio calculated by adding the relevant hospital entity's costs attributable to charity care, Medicaid, other means-tested government programs, Medicare patients with disabilities under age 65, and dual-eligible Medicare/Medicaid patients and dividing that total by the relevant hospital entity's total costs. Such costs for the numerator and denominator shall be determined by multiplying gross charges by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I). In the case of emergency services, the ratio shall be calculated using costs (gross charges multiplied by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

(7) Any other activity by the relevant hospital entity that the Department determines relieves the burden of government or addresses the health of low-income or underserved individuals.

(d) The hospital applicant shall include information in its exemption application establishing that it satisfies the

requirements of subsection (b). For purposes of making the calculations required by subsection (b), the hospital applicant may for each year elect to use either (1) the value of the services or activities listed in subsection (e) for the hospital year or (2) the average value of those services or activities for the 3 fiscal years ending with the hospital year. If the relevant hospital entity has been in operation for less than 3 completed fiscal years, then the latter calculation, if elected, shall be performed on a pro rata basis.

(e) For purposes of making the calculations required by this Section:

(1) particular services or activities eligible for consideration under any of the paragraphs (1) through (7) of subsection (c) may not be counted under more than one of those paragraphs; and

(2) the amount of unreimbursed costs and the amount of subsidy shall not be reduced by restricted or unrestricted payments received by the relevant hospital entity as contributions deductible under Section 170(a) of the Internal Revenue Code.

(f) (Blank).

(g) Estimation of Exempt Property Tax Liability. The estimated property tax liability used for the determination in subsection (b) shall be calculated as follows:

(1) "Estimated property tax liability" means the

estimated dollar amount of property tax that would be owed, with respect to the exempt portion of each of the relevant hospital entity's properties that are already fully or partially exempt, or for which an exemption in whole or in part is currently being sought, and then aggregated as applicable, as if the exempt portion of those properties were subject to tax, calculated with respect to each such property by multiplying:

(A) the lesser of (i) the actual assessed value, if any, of the portion of the property for which an exemption is sought or (ii) an estimated assessed value of the exempt portion of such property as determined in item (2) of this subsection (g), by

(B) the applicable State equalization rate (yielding the equalized assessed value), by

(C) the applicable tax rate.

(2) The estimated assessed value of the exempt portion of the property equals the sum of (i) the estimated fair market value of buildings on the property, as determined in accordance with subparagraphs (A) and (B) of this item (2), multiplied by the applicable assessment factor, and (ii) the estimated assessed value of the land portion of the property, as determined in accordance with subparagraph (C).

(A) The "estimated fair market value of buildings on the property" means the replacement value of any

exempt portion of buildings on the property, minus depreciation, determined utilizing the cost replacement method whereby the exempt square footage of all such buildings is multiplied by the replacement cost per square foot for Class A Average building found in the most recent edition of the Marshall & Swift Valuation Services Manual, adjusted by any appropriate current cost and local multipliers.

(B) Depreciation, for purposes of calculating the estimated fair market value of buildings on the property, is applied by utilizing a weighted mean life for the buildings based on original construction and assuming a 40-year life for hospital buildings and the applicable life for other types of buildings as specified in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets". In the case of hospital buildings, the remaining life is divided by 40 and this ratio is multiplied by the replacement cost of the buildings to obtain an estimated fair market value of buildings. If a hospital building is older than 35 years, a remaining life of 5 years for residual value is assumed; and if a building is less than 8 years old, a remaining life of 32 years is assumed.

(C) The estimated assessed value of the land portion of the property shall be determined by

multiplying (i) the per square foot average of the assessed values of three parcels of land (not including farm land, and excluding the assessed value of the improvements thereon) reasonably comparable to the property, by (ii) the number of square feet comprising the exempt portion of the property's land square footage.

(3) The assessment factor, State equalization rate, and tax rate (including any special factors such as Enterprise Zones) used in calculating the estimated property tax liability shall be for the most recent year that is publicly available from the applicable chief county assessment officer or officers at least 90 days before the end of the hospital year.

(4) The method utilized to calculate estimated property tax liability for purposes of this Section 15-86 shall not be utilized for the actual valuation, assessment, or taxation of property pursuant to the Property Tax Code.

(h) For the purpose of this Section, the following terms shall have the meanings set forth below:

(1) "Hospital" means any institution, place, building, buildings on a campus, or other health care facility located in Illinois that is licensed under the Hospital Licensing Act and has a hospital owner.

(2) "Hospital owner" means a not-for-profit corporation that is the titleholder of a hospital, or the

owner of the beneficial interest in an Illinois land trust that is the titleholder of a hospital.

(3) "Hospital affiliate" means any corporation, partnership, limited partnership, joint venture, limited liability company, association or other organization, other than a hospital owner, that directly or indirectly controls, is controlled by, or is under common control with one or more hospital owners and that supports, is supported by, or acts in furtherance of the exempt health care purposes of at least one of those hospital owners' hospitals.

(4) "Hospital system" means a hospital and one or more other hospitals or hospital affiliates related by common control or ownership.

(5) "Control" relating to hospital owners, hospital affiliates, or hospital systems means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the entity, whether through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

(6) "Hospital applicant" means a hospital owner or hospital affiliate that files an application for an exemption or renewal of exemption under this Section.

(7) "Relevant hospital entity" means (A) the hospital owner, in the case of a hospital applicant that is a hospital owner, and (B) at the election of a hospital

applicant that is a hospital affiliate, either (i) the hospital affiliate or (ii) the hospital system to which the hospital applicant belongs, including any hospitals or hospital affiliates that are related by common control or ownership.

(8) "Subject property" means property used for the calculation under subsection (b) of this Section.

(9) "Hospital year" means the fiscal year of the relevant hospital entity, or the fiscal year of one of the hospital owners in the hospital system if the relevant hospital entity is a hospital system with members with different fiscal years, that ends in the year for which the exemption is sought.

(i) It is the intent of the General Assembly that any exemptions taken, granted, or renewed under this Section prior to the effective date of this amendatory Act of the 100th General Assembly are hereby validated.

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

Section 30. The Retailers' Occupation Tax Act is amended by changing Section 2-9 as follows:

(35 ILCS 120/2-9)

Sec. 2-9. Hospital exemption.

(a) Until July 1, 2022, tangible ~~Tangible~~ personal property sold to or used by a hospital owner that owns one or more

hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act, or a hospital affiliate that is not already exempt under another provision of this Act and meets the criteria for an exemption under this Section, is exempt from taxation under this Act.

(b) A hospital owner or hospital affiliate satisfies the conditions for an exemption under this Section if the value of qualified services or activities listed in subsection (c) of this Section for the hospital year equals or exceeds the relevant hospital entity's estimated property tax liability, without regard to any property tax exemption granted under Section 15-86 of the Property Tax Code, for the calendar year in which exemption or renewal of exemption is sought. For purposes of making the calculations required by this subsection (b), if the relevant hospital entity is a hospital owner that owns more than one hospital, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities relating to the hospital that includes the subject property, and the relevant hospital entity's estimated property tax liability shall be calculated only with respect to the properties comprising that hospital. In the case of a multi-state hospital system or hospital affiliate, the value of the services or activities listed in subsection (c) shall be calculated on the basis of only those services and activities that occur in Illinois and the relevant hospital entity's estimated property tax

liability shall be calculated only with respect to its property located in Illinois.

(c) The following services and activities shall be considered for purposes of making the calculations required by subsection (b):

(1) Charity care. Free or discounted services provided pursuant to the relevant hospital entity's financial assistance policy, measured at cost, including discounts provided under the Hospital Uninsured Patient Discount Act.

(2) Health services to low-income and underserved individuals. Other unreimbursed costs of the relevant hospital entity for providing without charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals. Those activities or services may include, but are not limited to: financial or in-kind support to affiliated or unaffiliated hospitals, hospital affiliates, community clinics, or programs that treat low-income or underserved individuals; paying for or subsidizing health care professionals who care for low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals

because of their medical condition; and prenatal or childbirth outreach to low-income or underserved persons.

(3) Subsidy of State or local governments. Direct or indirect financial or in-kind subsidies of State or local governments by the relevant hospital entity that pay for or subsidize activities or programs related to health care for low-income or underserved individuals.

(4) Support for State health care programs for low-income individuals. At the election of the hospital applicant for each applicable year, either (A) 10% of payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested

programs, including but not limited to General Assistance, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program. The amount of subsidy for purposes of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly.

(5) Dual-eligible subsidy. The amount of subsidy provided to government by treating dual-eligible Medicare/Medicaid patients. The amount of subsidy for purposes of this item (5) is calculated by multiplying the relevant hospital entity's unreimbursed costs for Medicare, calculated in the same manner as determined in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly, by the relevant hospital entity's ratio of dual-eligible patients to total Medicare patients.

(6) Relief of the burden of government related to health care. Except to the extent otherwise taken into account in this subsection, the portion of unreimbursed costs of the relevant hospital entity attributable to providing, paying for, or subsidizing goods, activities, or services that relieve the burden of government related to health care for low-income individuals. Such activities or services shall include, but are not limited to,

providing emergency, trauma, burn, neonatal, psychiatric, rehabilitation, or other special services; providing medical education; and conducting medical research or training of health care professionals. The portion of those unreimbursed costs attributable to benefiting low-income individuals shall be determined using the ratio calculated by adding the relevant hospital entity's costs attributable to charity care, Medicaid, other means-tested government programs, Medicare patients with disabilities under age 65, and dual-eligible Medicare/Medicaid patients and dividing that total by the relevant hospital entity's total costs. Such costs for the numerator and denominator shall be determined by multiplying gross charges by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I). In the case of emergency services, the ratio shall be calculated using costs (gross charges multiplied by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

(7) Any other activity by the relevant hospital entity that the Department determines relieves the burden of government or addresses the health of low-income or underserved individuals.

(d) The hospital applicant shall include information in its

exemption application establishing that it satisfies the requirements of subsection (b). For purposes of making the calculations required by subsection (b), the hospital applicant may for each year elect to use either (1) the value of the services or activities listed in subsection (e) for the hospital year or (2) the average value of those services or activities for the 3 fiscal years ending with the hospital year. If the relevant hospital entity has been in operation for less than 3 completed fiscal years, then the latter calculation, if elected, shall be performed on a pro rata basis.

(e) For purposes of making the calculations required by this Section:

(1) particular services or activities eligible for consideration under any of the paragraphs (1) through (7) of subsection (c) may not be counted under more than one of those paragraphs; and

(2) the amount of unreimbursed costs and the amount of subsidy shall not be reduced by restricted or unrestricted payments received by the relevant hospital entity as contributions deductible under Section 170(a) of the Internal Revenue Code.

(f) (Blank).

(g) Estimation of Exempt Property Tax Liability. The estimated property tax liability used for the determination in subsection (b) shall be calculated as follows:

(1) "Estimated property tax liability" means the estimated dollar amount of property tax that would be owed, with respect to the exempt portion of each of the relevant hospital entity's properties that are already fully or partially exempt, or for which an exemption in whole or in part is currently being sought, and then aggregated as applicable, as if the exempt portion of those properties were subject to tax, calculated with respect to each such property by multiplying:

(A) the lesser of (i) the actual assessed value, if any, of the portion of the property for which an exemption is sought or (ii) an estimated assessed value of the exempt portion of such property as determined in item (2) of this subsection (g), by

(B) the applicable State equalization rate (yielding the equalized assessed value), by

(C) the applicable tax rate.

(2) The estimated assessed value of the exempt portion of the property equals the sum of (i) the estimated fair market value of buildings on the property, as determined in accordance with subparagraphs (A) and (B) of this item (2), multiplied by the applicable assessment factor, and (ii) the estimated assessed value of the land portion of the property, as determined in accordance with subparagraph (C).

(A) The "estimated fair market value of buildings

on the property" means the replacement value of any exempt portion of buildings on the property, minus depreciation, determined utilizing the cost replacement method whereby the exempt square footage of all such buildings is multiplied by the replacement cost per square foot for Class A Average building found in the most recent edition of the Marshall & Swift Valuation Services Manual, adjusted by any appropriate current cost and local multipliers.

(B) Depreciation, for purposes of calculating the estimated fair market value of buildings on the property, is applied by utilizing a weighted mean life for the buildings based on original construction and assuming a 40-year life for hospital buildings and the applicable life for other types of buildings as specified in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets". In the case of hospital buildings, the remaining life is divided by 40 and this ratio is multiplied by the replacement cost of the buildings to obtain an estimated fair market value of buildings. If a hospital building is older than 35 years, a remaining life of 5 years for residual value is assumed; and if a building is less than 8 years old, a remaining life of 32 years is assumed.

(C) The estimated assessed value of the land

portion of the property shall be determined by multiplying (i) the per square foot average of the assessed values of three parcels of land (not including farm land, and excluding the assessed value of the improvements thereon) reasonably comparable to the property, by (ii) the number of square feet comprising the exempt portion of the property's land square footage.

(3) The assessment factor, State equalization rate, and tax rate (including any special factors such as Enterprise Zones) used in calculating the estimated property tax liability shall be for the most recent year that is publicly available from the applicable chief county assessment officer or officers at least 90 days before the end of the hospital year.

(4) The method utilized to calculate estimated property tax liability for purposes of this Section 15-86 shall not be utilized for the actual valuation, assessment, or taxation of property pursuant to the Property Tax Code.

(h) For the purpose of this Section, the following terms shall have the meanings set forth below:

(1) "Hospital" means any institution, place, building, buildings on a campus, or other health care facility located in Illinois that is licensed under the Hospital Licensing Act and has a hospital owner.

(2) "Hospital owner" means a not-for-profit

corporation that is the titleholder of a hospital, or the owner of the beneficial interest in an Illinois land trust that is the titleholder of a hospital.

(3) "Hospital affiliate" means any corporation, partnership, limited partnership, joint venture, limited liability company, association or other organization, other than a hospital owner, that directly or indirectly controls, is controlled by, or is under common control with one or more hospital owners and that supports, is supported by, or acts in furtherance of the exempt health care purposes of at least one of those hospital owners' hospitals.

(4) "Hospital system" means a hospital and one or more other hospitals or hospital affiliates related by common control or ownership.

(5) "Control" relating to hospital owners, hospital affiliates, or hospital systems means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the entity, whether through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

(6) "Hospital applicant" means a hospital owner or hospital affiliate that files an application for an exemption or renewal of exemption under this Section.

(7) "Relevant hospital entity" means (A) the hospital owner, in the case of a hospital applicant that is a

hospital owner, and (B) at the election of a hospital applicant that is a hospital affiliate, either (i) the hospital affiliate or (ii) the hospital system to which the hospital applicant belongs, including any hospitals or hospital affiliates that are related by common control or ownership.

(8) "Subject property" means property used for the calculation under subsection (b) of this Section.

(9) "Hospital year" means the fiscal year of the relevant hospital entity, or the fiscal year of one of the hospital owners in the hospital system if the relevant hospital entity is a hospital system with members with different fiscal years, that ends in the year for which the exemption is sought.

(i) It is the intent of the General Assembly that any exemptions taken, granted, or renewed under this Section prior to the effective date of this amendatory Act of the 100th General Assembly are hereby validated.

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

Section 35. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 2-101 and 4-102 as follows:

(210 ILCS 49/2-101)

Sec. 2-101. Standards for facilities.

(a) The Department shall, by rule, prescribe minimum standards for each level of care for facilities to be in place during the provisional licensure period and thereafter. These standards shall include, but are not limited to, the following:

(1) life safety standards that will ensure the health, safety and welfare of residents and their protection from hazards;

(2) number and qualifications of all personnel, including management and clinical personnel, having responsibility for any part of the care given to consumers; specifically, the Department shall establish staffing ratios for facilities which shall specify the number of staff hours per consumer of care that are needed for each level of care offered within the facility;

(3) all sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which shall ensure the health and comfort of consumers;

(4) a program for adequate maintenance of physical plant and equipment;

(5) adequate accommodations, staff, and services for the number and types of services being offered to consumers for whom the facility is licensed to care;

(6) development of evacuation and other appropriate safety plans for use during weather, health, fire, physical plant, environmental, and national defense emergencies;

(7) maintenance of minimum financial or other resources necessary to meet the standards established under this Section, and to operate and conduct the facility in accordance with this Act; and

(8) standards for coercive free environment, restraint, and therapeutic separation.

(b) Any requirement contained in administrative rule concerning a percentage of single occupancy rooms shall be calculated based on the total number of licensed or provisionally licensed beds under this Act on January 1, 2019 and shall not be calculated on a per-facility basis.

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/4-102)

Sec. 4-102. Necessity of license. No person may establish, operate, maintain, offer, or advertise a facility within this State unless and until he or she obtains a valid license therefor as hereinafter provided, which license remains unsuspended, unrevoked, and unexpired. No public official or employee may place any person in, or recommend that any person be in, or directly or indirectly cause any person to be placed in any facility that is being operated without a valid license. All licenses and licensing procedures established under Article III of the Nursing Home Care Act, except those contained in Section 3-202, shall be deemed valid under this Act until the Department establishes licensure. The Department

is granted the authority under this Act to establish provisional licensure and licensing procedures under this Act by emergency rule and shall do so within 120 days of the effective date of this Act. The Department shall not grant a provisional license to any facility that does not possess a provisional license on November 30, 2018 and is licensed under the Nursing Home Care Act on or before November 30, 2018. The Department shall not grant a license to any facility that has not first received a provisional license. The changes made by this amendatory Act of the 100th General Assembly do not apply to the provisions of subsection (c) of Section 1-101.5 concerning facility closure and relocation.

(Source: P.A. 98-104, eff. 7-22-13.)

Section 40. The Illinois Public Aid Code is amended by changing Sections 5-5.07, 5A-4, 5A-13, and 14-12 as follows:

(305 ILCS 5/5-5.07)

(Section scheduled to be repealed on January 27, 2019)

Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem rate. The Department of Children and Family Services shall pay the DCFS per diem rate for inpatient psychiatric stay at a free-standing psychiatric hospital effective the 11th day when a child is in the hospital beyond medical necessity, and the parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living

arrangement for the child or the child's discharge is being delayed due to a pending inquiry or investigation by the Department of Children and Family Services. This Section is repealed on July 1, 2019 ~~6 months after the effective date of this amendatory Act of the 100th General Assembly~~.

(Source: P.A. 100-646, eff. 7-27-18.)

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

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

(a) The assessment imposed by Section 5A-2 for State fiscal year 2009 through State fiscal year 2018 or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the fourteenth State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after the Comptroller has issued the payments required under this Article.

Except as provided in subsection (a-5) of this Section, the assessment imposed by subsection (b-5) of Section 5A-2 for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal year 2013 through State fiscal year 2018 or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 17th ~~14th~~ State business day of each month. No installment payment of an assessment imposed by subsection (b-5) of Section 5A-2 shall be

due and payable, however, until after: (i) the Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12.4, have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and the waiver under 42 CFR 433.68 for the assessment imposed by subsection (b-5) of Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.4. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.4 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b-5) of Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4.

Except as provided in subsection (a-5) of this Section, the assessment imposed under Section 5A-2 for State fiscal year 2019 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 14th State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after: (i) the Department notifies the hospital provider, in writing,

that the payment methodologies to hospitals required under Section 5A-12.6 have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and the waiver under 42 CFR 433.68 for the assessment imposed by Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.6. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.6 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.6.

(a-5) The Illinois Department may accelerate the schedule upon which assessment installments are due and payable by hospitals with a payment ratio greater than or equal to one. Such acceleration of due dates for payment of the assessment may be made only in conjunction with a corresponding acceleration in access payments identified in Section 5A-12.2, Section 5A-12.4, or Section 5A-12.6 to the same hospitals. For the purposes of this subsection (a-5), a hospital's payment ratio is defined as the quotient obtained by dividing the total payments for the State fiscal year, as authorized under Section 5A-12.2, Section 5A-12.4, or Section 5A-12.6, by the total

assessment for the State fiscal year imposed under Section 5A-2 or subsection (b-5) of Section 5A-2.

(b) The Illinois Department is authorized to establish delayed payment schedules for hospital providers that are unable to make installment payments when due under this Section due to financial difficulties, as determined by the Illinois Department.

(c) If a hospital provider fails to pay the full amount of an 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 5A-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the installment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter or (ii) 100% of the installment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

(d) Any assessment amount that is due and payable to the Illinois Department more frequently than once per calendar quarter shall be remitted to the Illinois Department by the hospital provider by means of electronic funds transfer. The Illinois Department may provide for remittance by other means if (i) the amount due is less than $10,000 or (ii) electronic

funds transfer is unavailable for this purpose.

(Source: P.A. 100-581, eff. 3-12-18.)

(305 ILCS 5/5A-13)

Sec. 5A-13. Emergency rulemaking.

(a) The Department of Healthcare and Family Services (formerly Department of Public Aid) may adopt rules necessary to implement this amendatory Act of the 94th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 94th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(b) The Department of Healthcare and Family Services may adopt rules necessary to implement this amendatory Act of the 97th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 97th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(c) The Department of Healthcare and Family Services may adopt rules necessary to initially implement the changes to Articles 5, 5A, 12, and 14 of this Code under this amendatory Act of the 100th General Assembly through the use of emergency

rulemaking in accordance with subsection (aa) of Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement the changes to Articles 5, 5A, 12, and 14 of this Code under this amendatory Act of the 100th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted to initially implement the changes to Articles 5, 5A, 12, and 14 of this Code under this amendatory Act of the 100th General Assembly. For purposes of this subsection, "initially" means any emergency rules necessary to immediately implement the changes authorized to Articles 5, 5A, 12, and 14 of this Code under this amendatory Act of the 100th General Assembly; however, emergency rulemaking authority shall not be used to make changes that could otherwise be made following the process established in the Illinois Administrative Procedure Act.

(d) The Department of Healthcare and Family Services may on a one-time-only basis adopt rules necessary to initially implement the changes to Articles 5A and 14 of this Code under this amendatory Act of the 100th General Assembly through the use of emergency rulemaking in accordance with subsection (ee) of Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules on a one-time-only basis to implement the changes to Articles 5A and 14 of this Code under this

amendatory Act of the 100th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted to initially implement the changes to Articles 5A and 14 of this Code under this amendatory Act of the 100th General Assembly.

(Source: P.A. 100-581, eff. 3-12-18.)

(305 ILCS 5/14-12)

Sec. 14-12. Hospital rate reform payment system. The hospital payment system pursuant to Section 14-11 of this Article shall be as follows:

(a) Inpatient hospital services. Effective for discharges on and after July 1, 2014, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, version 30, distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 30.0 adjusted for the Illinois experience.

(2) The Department shall establish a statewide-standardized amount to be used in the inpatient reimbursement system. The Department shall publish these

amounts on its website no later than 10 calendar days prior to their effective date.

(3) In addition to the statewide-standardized amount, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid providers or services for trauma, transplantation services, perinatal care, and Graduate Medical Education (GME).

(4) The Department shall develop add-on payments to account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive growth in outlier payments no more frequently than on an annual basis, but at least triennially. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

(5) The Department shall define those hospitals or distinct parts of hospitals that shall be exempt from the APR-DRG reimbursement system established under this Section. The Department shall publish these hospitals' inpatient rates on its website no later than 10 calendar days prior to their effective date.

(6) Beginning July 1, 2014 and ending on June 30, 2024, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

(7) Beginning July 1, 2014 and ending on June 30, 2020, or upon implementation of inpatient psychiatric rate increases as described in subsection (n) of Section 5A-12.6, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(7.5) Beginning July 1, 2020, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%. Beginning July 1, 2022, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%. Beginning July 1, 2024, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (4)

of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%.

(8) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall adjust the rate of reimbursement for hospitals designated by the Department of Public Health as a Perinatal Level II or II+ center by applying the same adjustor that is applied to Perinatal and Obstetrical care cases for Perinatal Level III centers, as of December 31, 2017.

(9) Beginning July 1, 2018, in addition to the statewide-standardized amount, the Department shall apply the same adjustor that is applied to trauma cases as of December 31, 2017 to inpatient claims to treat patients with burns, including, but not limited to, APR-DRGs 841, 842, 843, and 844.

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2020, the statewide-standardized amount for

inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2022, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2023 the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%.

(11) Beginning July 1, 2018, the reimbursement for inpatient rehabilitation services shall be increased by the addition of a $96 per day add-on.

Beginning July 1, 2020, the reimbursement for

inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on is increased by an amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 0.9%.

Beginning July 1, 2022, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on as adjusted by the July 1, 2020 increase, is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 0.9%.

Beginning July 1, 2023, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on as adjusted by the July 1, 2022 increase, is increased by an amount equal to the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 0.9%.

(b) Outpatient hospital services. Effective for dates of service on and after July 1, 2014, reimbursement for outpatient services shall utilize the Enhanced Ambulatory Procedure

Grouping (EAPG ~~E-APG~~) software, version 3.7 distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. The initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 3.7.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year 2013 Medicare Outpatient Prospective Payment System wage index with reclassifications, shall be published by the Department on its website no later than 10 calendar days prior to their effective date.

(B) The Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F. For outpatient services provided on or before June 30, 2018, the ~~The~~ EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments under Section 5A-12.4 of this Code net of the associated tax costs are equal to

the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals. Beginning July 1, 2018, the outpatient high volume adjustor shall be increased to increase annual expenditures associated with this adjustor by $79,200,000, based on the State Fiscal Year 2015 base year data and this adjustor shall apply to public hospitals, except for large public hospitals, as defined under 89 Ill. Adm. Code 148.25(a).

(4) Beginning July 1, 2018, in addition to the statewide standardized amounts, the Department shall make an add-on payment for outpatient expensive devices and drugs. This add-on payment shall at least apply to claim lines that: (i) are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or (ii) are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090. The add-on payment shall be calculated as follows: the claim line's covered charges multiplied by the hospital's total acute cost to charge ratio, less the claim line's EAPG payment plus $1,000, multiplied by 0.8.

(5) Beginning July 1, 2018, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. Beginning July 1, 2020, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. Beginning July 1, 2022, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. Beginning July 1, 2023, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is

increased by an amount equal to no less than the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%.

(6) Effective for dates of service on or after July 1, 2018, the Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F, such that each Critical Access Hospital's standardized amount for outpatient services shall be increased by the applicable uniform percentage determined pursuant to paragraph (5) of this subsection. It is the intent of the General Assembly that the adjustments required under this paragraph (6) by this amendatory Act of the 100th General Assembly shall be applied retroactively to claims for dates of service provided on or after July 1, 2018.

(7) Effective for dates of service on or after the effective date of this amendatory Act of the 100th General Assembly, the Department shall recalculate and implement an updated statewide-standardized amount for outpatient services provided by hospitals that are not Critical Access Hospitals to reflect the applicable uniform percentage determined pursuant to paragraph (5).

(1) Any recalculation to the

statewide-standardized amounts for outpatient services provided by hospitals that are not Critical Access Hospitals shall be the amount necessary to achieve the increase in the statewide-standardized amounts for outpatient services increased by a uniform percentage, so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection, for all hospitals that are not Critical Access Hospitals, multiplied by 46%.

(2) It is the intent of the General Assembly that the recalculations required under this paragraph (7) by this amendatory Act of the 100th General Assembly shall be applied prospectively to claims for dates of service provided on or after the effective date of this amendatory Act of the 100th General Assembly and that no recoupment or repayment by the Department or an MCO of payments attributable to recalculation under this paragraph (7), issued to the hospital for dates of service on or after July 1, 2018 and before the effective date of this amendatory Act of the 100th General Assembly, shall be permitted.

(8) The Department shall ensure that all necessary adjustments to the managed care organization capitation

base rates necessitated by the adjustments under subparagraph (6) or (7) of this subsection are completed and applied retroactively in accordance with Section 5-30.8 of this Code within 90 days of the effective date of this amendatory Act of the 100th General Assembly.

(c) In consultation with the hospital community, the Department is authorized to replace 89 Ill. Admin. Code 152.150 as published in 38 Ill. Reg. 4980 through 4986 within 12 months of June 16, 2014 (the effective date of Public Act 98-651) ~~this amendatory Act of the 98th General Assembly~~. If the Department does not replace these rules within 12 months of June 16, 2014 (the effective date of Public Act 98-651) ~~this amendatory Act of the 98th General Assembly~~, the rules in effect for 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall remain in effect until modified by rule by the Department. Nothing in this subsection shall be construed to mandate that the Department file a replacement rule.

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access

payments are made to hospitals.

(1) After the transition period, the Department may begin incorporating the transitional hospital access pool into the base rate structure; however, the transitional hospital access payments in effect on June 30, 2018 shall continue to be paid, if continued under Section 5A-16.

(2) After the transition period, if the Department reduces payments from the transitional hospital access pool, it shall increase base rates, develop new adjustors, adjust current adjustors, develop new hospital access payments based on updated information, or any combination thereof by an amount equal to the decreases proposed in the transitional hospital access pool payments, ensuring that the entire transitional hospital access pool amount shall continue to be used for hospital payments.

(d-5) Hospital transformation program. The Department, in conjunction with the Hospital Transformation Review Committee created under subsection (d-5), shall develop a hospital transformation program to provide financial assistance to hospitals in transforming their services and care models to better align with the needs of the communities they serve. The payments authorized in this Section shall be subject to approval by the federal government.

(1) Phase 1. In State fiscal years 2019 through 2020, the Department shall allocate funds from the transitional access hospital pool to create a hospital transformation

pool of at least $262,906,870 annually and make hospital transformation payments to hospitals. Subject to Section 5A-16, in State fiscal years 2019 and 2020, an Illinois hospital that received either a transitional hospital access payment under subsection (d) or a supplemental payment under subsection (f) of this Section in State fiscal year 2018, shall receive a hospital transformation payment as follows:

(A) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 45%, the hospital transformation payment shall be equal to 100% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(B) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is equal to or greater than 25% but less than 45%, the hospital transformation payment shall be equal to 75% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(C) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is less than 25%, the hospital transformation payment shall be equal to 50% of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental

payment authorized under subsection (f).

(2) Phase 2. During State fiscal years 2021 and 2022, the Department shall allocate funds from the transitional access hospital pool to create a hospital transformation pool annually and make hospital transformation payments to hospitals participating in the transformation program. Any hospital may seek transformation funding in Phase 2. Any hospital that seeks transformation funding in Phase 2 to update or repurpose the hospital's physical structure to transition to a new delivery model, must submit to the Department in writing a transformation plan, based on the Department's guidelines, that describes the desired delivery model with projections of patient volumes by service lines and projected revenues, expenses, and net income that correspond to the new delivery model. In Phase 2, subject to the approval of rules, the Department may use the hospital transformation pool to increase base rates, develop new adjustors, adjust current adjustors, or develop new access payments in order to support and incentivize hospitals to pursue such transformation. In developing such methodologies, the Department shall ensure that the entire hospital transformation pool continues to be expended to ensure access to hospital services or to support organizations that had received hospital transformation payments under this Section.

(A) Any hospital participating in the hospital

transformation program shall provide an opportunity for public input by local community groups, hospital workers, and healthcare professionals and assist in facilitating discussions about any transformations or changes to the hospital.

(B) As provided in paragraph (9) of Section 3 of the Illinois Health Facilities Planning Act, any hospital participating in the transformation program may be excluded from the requirements of the Illinois Health Facilities Planning Act for those projects related to the hospital's transformation. To be eligible, the hospital must submit to the Health Facilities and Services Review Board certification from the Department, approved by the Hospital Transformation Review Committee, that the project is a part of the hospital's transformation.

(C) As provided in subsection (a-20) of Section 32.5 of the Emergency Medical Services (EMS) Systems Act, a hospital that received hospital transformation payments under this Section may convert to a freestanding emergency center. To be eligible for such a conversion, the hospital must submit to the Department of Public Health certification from the Department, approved by the Hospital Transformation Review Committee, that the project is a part of the hospital's transformation.

(3) By April 1, 2019 ~~Within 6 months after the effective date of this amendatory Act of the 100th General Assembly,~~ the Department, in conjunction with the Hospital Transformation Review Committee, shall develop and file as an administrative rule with the Secretary of State ~~adopt, by rule,~~ the goals, objectives, policies, standards, payment models, or criteria to be applied in Phase 2 of the program to allocate the hospital transformation funds. The goals, objectives, and policies to be considered may include, but are not limited to, achieving unmet needs of a community that a hospital serves such as behavioral health services, outpatient services, or drug rehabilitation services; attaining certain quality or patient safety benchmarks for health care services; or improving the coordination, effectiveness, and efficiency of care delivery. Notwithstanding any other provision of law, any rule adopted in accordance with this subsection (d-5) may be submitted to the Joint Committee on Administrative Rules for approval only if the rule has first been approved by 9 of the 14 members of the Hospital Transformation Review Committee.

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 14 members. No later than 30 days after March 12, 2018 (the effective date of Public Act 100-581) ~~this amendatory Act of the 100th General Assembly~~,

the 4 legislative leaders shall each appoint 3 members; the Governor shall appoint the Director of Healthcare and Family Services, or his or her designee, as a member; and the Director of Healthcare and Family Services shall appoint one member. Any vacancy shall be filled by the applicable appointing authority within 15 calendar days. The members of the Committee shall select a Chair and a Vice-Chair from among its members, provided that the Chair and Vice-Chair cannot be appointed by the same appointing authority and must be from different political parties. The Chair shall have the authority to establish a meeting schedule and convene meetings of the Committee, and the Vice-Chair shall have the authority to convene meetings in the absence of the Chair. The Committee may establish its own rules with respect to meeting schedule, notice of meetings, and the disclosure of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 9 of the 14 members. The Committee shall perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members

of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. The Committee is dissolved on April 1, 2019.

(e) Beginning 36 months after initial implementation, the Department shall update the reimbursement components in subsections (a) and (b), including standardized amounts and weighting factors, and at least triennially and no more frequently than annually thereafter. The Department shall publish these updates on its website no later than 30 calendar days prior to their effective date.

(f) Continuation of supplemental payments. Any supplemental payments authorized under Illinois Administrative Code 148 effective January 1, 2014 and that continue during the period of July 1, 2014 through December 31, 2014 shall remain in effect as long as the assessment imposed by Section 5A-2 that is in effect on December 31, 2017 remains in effect.

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system

(July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including but not limited to the number of individuals in the medical assistance program and the severity of illness of the individuals.

(h) The Department shall have the authority to modify by rulemaking any changes to the rates or methodologies in this Section as required by the federal government to obtain federal financial participation for expenditures made under this Section.

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977

(Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

(j) Out-of-state hospitals. Beginning July 1, 2018, for purposes of determining for State fiscal years 2019 and 2020 the hospitals eligible for the payments authorized under subsections (a) and (b) of this Section, the Department shall include out-of-state hospitals that are designated a Level I pediatric trauma center or a Level I trauma center by the Department of Public Health as of December 1, 2017.

(k) The Department shall notify each hospital and managed care organization, in writing, of the impact of the updates under this Section at least 30 calendar days prior to their effective date.

(Source: P.A. 99-2, eff. 3-26-15; 100-581, eff. 3-12-18; revised 10-3-18.)

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

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