AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Sections 5-4.2, 5-5.4, 5B-2, 5B-4, and 5B-8 as follows:

(305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

Sec. 5-4.2. Ambulance services payments.

(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a reimbursement system for ambulance services that, to the extent practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure

uniformity between the payment principles of Medicare and Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).

(b) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1996, the Illinois Department shall reimburse ambulance service providers based upon the actual distance traveled if a natural disaster, weather conditions, road repairs, or traffic congestion necessitates the use of a route other than the most direct route.

(c) For purposes of this Section, "ambulance services" includes medical transportation services provided by means of an ambulance, medi-car, service car, or taxi.

(c-1) For purposes of this Section, "ground ambulance service" means medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and provided in a vehicle that is licensed as an ambulance by the Illinois Department of Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.

(c-2) For purposes of this Section, "ground ambulance

service provider" means a vehicle service provider as described in the Emergency Medical Services (EMS) Systems Act that operates licensed ambulances for the purpose of providing emergency ambulance services, or non-emergency ambulance services, or both. For purposes of this Section, this includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.

(d) This Section does not prohibit separate billing by ambulance service providers for oxygen furnished while providing advanced life support services.

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years.

Notwithstanding the requirements above, any public transportation provider of medi-car and service car transportation that receives federal funding under 49 U.S.C. 5307 and 5311 need not certify its drivers and employee attendants under this Section, since safety training is already federally mandated.

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be established within 12 months after the effective date of this amendatory Act of the 97th General Assembly and shall provide that, for any decision rendered by

the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(Source: P.A. 95-501, eff. 8-28-07.)

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

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

(1) Provide for the determination of a facility's payment for nursing facility or ICF/DD services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under the MR/DD Community Care Act or the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities, Long Term Care for Under Age 22 facilities, Skilled Nursing facilities, or Intermediate Care facilities under the medical assistance program shall be prospectively established annually on the basis of historical, financial, and statistical data

reflecting actual costs from prior years, which shall be applied to the current rate year and updated for inflation, except that the capital cost element for newly constructed facilities shall be based upon projected budgets. The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994 and before July 1, 2012, unless specifically provided for in this Section. The changes made by Public Act 93-841 extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

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

Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2009 shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive staff.

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

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

per resident-day, as defined by the Department.

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

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

by that facility.

(B) For a facility that would receive a higher nursing component rate per patient day under the payment methodology in effect on July 1, 2003 than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be adjusted.

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

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, except facilities participating in the Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, the numerator of the ratio used by the Department of Healthcare and Family Services to compute the

rate payable under this Section using the Minimum Data Set (MDS) methodology shall incorporate the following annual amounts as the additional funds appropriated to the Department specifically to pay for rates based on the MDS nursing component methodology in excess of the funding in effect on December 31, 2006:

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

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

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

(iv) For rates taking effect April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, $416,500,000 or an amount as may be necessary to complete the transition to the MDS methodology for the nursing component of the rate. Increased payments under this item (iv) are not due and payable, however, until (i) the methodologies described in this paragraph are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under

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

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on April 1, 2002 shall include a statewide increase of 2.0%, as defined by the Department. This increase terminates on July 1, 2002; beginning July 1, 2002 these rates are reduced to the level of the rates in effect on March 31, 2002, as defined by the Department.

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or

intermediate care facilities, the Illinois Department shall determine by rule the rates taking effect on July 1, 2002, which shall be 5.9% less than the rates in effect on June 30, 2002.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved by the United States Centers for Medicare and Medicaid Services, the rates taking effect on July 1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2009, the per diem support component of the rates effective on January 1,

2008, computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006, shall be increased to the amount that would have been derived using standard Department of Healthcare and Family Services methods, procedures, and inflators.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate shall be increased by a factor of 2.53 on the first day of the month that begins at least 45 days after January 11, 2008 (the effective date of Public Act 95-707). As of August 1, 2008, the socio-development component rate shall be equal to 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53. For services provided on or after April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, whichever is later, the Illinois Department may by rule adjust these socio-development component rates, and may use different adjustment methodologies for those facilities participating, and those not participating, in the Illinois

Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, but in no case may such rates be diminished below those in effect on August 1, 2008.

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

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2005, facility rates shall be increased by the difference between (i) a facility's per diem property, liability, and malpractice insurance costs as reported in the cost report filed with the Department of Public Aid and used to establish rates effective

July 1, 2001 and (ii) those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations, except for adjustments required under normal auditing procedures.

Rates established effective each July 1 shall govern payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for the year beginning July 1, 1990, and for subsequent years thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

(2) Shall take into account the actual costs incurred by

facilities in providing services for recipients of skilled nursing and intermediate care services under the medical assistance program.

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

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

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

The Department shall develop enhanced payments to offset the additional costs incurred by a facility serving exceptional need residents and shall allocate at least $8,000,000 of the funds collected from the assessment established by Section 5B-2 of this Code for such payments. For the purpose of this

Section, "exceptional needs" means, but need not be limited to, ventilator care, tracheotomy care, bariatric care, complex wound care, and traumatic brain injury care. The enhanced payments for exceptional need residents under this paragraph are not due and payable, however, until (i) the methodologies described in this paragraph are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

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

(6) No payment increase under this Section for the MDS methodology, exceptional care residents, or the socio-development component rate established by Public Act 96-1530 of the 96th General Assembly and funded by the assessment imposed under Section 5B-2 of this Code shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under this Section have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for

Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under this Section and the waivers granted under 42 CFR 433.68, all increased payments otherwise due under this Section prior to the date of notification shall be due and payable within 90 days of the date federal approval is received.

(Source: P.A. 95-12, eff. 7-2-07; 95-331, eff. 8-21-07; 95-707, eff. 1-11-08; 95-744, eff. 7-18-08; 96-45, eff. 7-15-09; 96-339, eff. 7-1-10; 96-959, eff. 7-1-10; 96-1000, eff. 7-2-10; 96-1530, eff. 2-16-11.)

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

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

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 an assessment is imposed upon each long-term care provider in an amount equal to $6.07 times the number of occupied bed days due and payable each month. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider ~~may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-state medical care program~~.

(b) Nothing in this amendatory Act of 1992 shall be

construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon long-term care providers or the occupation of long-term care provider, or a tax or assessment measured by the income or earnings or occupied bed days of a long-term care provider.

(c) The assessment imposed by this Section shall not be due and payable, however, until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(Source: P.A. 96-1530, eff. 2-16-11.)

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

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

(a) The assessment imposed by Section 5B-2 shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the

due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

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

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

Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under this Article if the long-term care provider has not been paid for services provided during the month on which the assessment is levied.

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

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

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

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

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

(f) No installment of the assessment imposed by Section 5B-2 shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.4 of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.4 of this Code.

(Source: P.A. 96-444, eff. 8-14-09; 96-1530, eff. 2-16-11.)

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

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

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

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

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

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake.

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

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

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

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

(6) For making transfers, at the direction of the Director of the Governor's Office of Management and Budget during each fiscal year beginning on or after July 1, 2011, to other State funds in an annual amount of $20,000,000 of the tax collected pursuant to this Article for the purpose of enforcement of nursing home standards, support of the ombudsman program, and efforts to expand home and community-based services. No transfer under this paragraph shall occur until (i) the payment methodologies created by Public Act 96-1530 under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

Disbursements from the Fund, other than transfers made

pursuant to paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

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

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

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

(4) (Blank).

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

(Source: P.A. 95-707, eff. 1-11-08; 96-1530, eff. 2-16-11.)

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