LRB10212590KTG39047a

Sen. Ann Gillespie

Filed: 4/8/2022

1 AMENDMENT TO HOUSE BILL 1950

2 AMENDMENT NO. ______. Amend House Bill 1950, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

5 "ARTICLE 5.

6 Section 5-5. The Illinois Public Aid Code is amended by
7 changing Sections 5-5e.1, 5A-2, 5A-5, 5A-8, 5A-10, 5A-12.7,
8 and 5A-14 as follows:

9 (305 ILCS 5/5-5e.1)
10 Sec. 5-5e.1. Safety-Net Hospitals.
11 (a) A Safety-Net Hospital is an Illinois hospital that:
12 (1) is licensed by the Department of Public Health as
13 a general acute care or pediatric hospital; and
14 (2) is a disproportionate share hospital, as described
15 in Section 1923 of the federal Social Security Act, as

1 determined by the Department; and
2 (3) meets one of the following:
3 (A) has a MIUR of at least 40% and a charity
4 percent of at least 4%; or
5 (B) has a MIUR of at least 50%.
6 (b) Definitions. As used in this Section:
7 (1) "Charity percent" means the ratio of (i) the
8 hospital's charity charges for services provided to
9 individuals without health insurance or another source of
10 third party coverage to (ii) the Illinois total hospital
11 charges, each as reported on the hospital's OBRA form.
12 (2) "MIUR" means Medicaid Inpatient Utilization Rate
13 and is defined as a fraction, the numerator of which is the
14 number of a hospital's inpatient days provided in the
15 hospital's fiscal year ending 3 years prior to the rate
16 year, to patients who, for such days, were eligible for
17 Medicaid under Title XIX of the federal Social Security
18 Act, 42 USC 1396a et seq., excluding those persons
19 eligible for medical assistance pursuant to 42 U.S.C.
20 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
21 Section 5-2 of this Article, and the denominator of which
22 is the total number of the hospital's inpatient days in
23 that same period, excluding those persons eligible for
24 medical assistance pursuant to 42 U.S.C.
25 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
26 Section 5-2 of this Article.

(3) "OBRA form" means form HFS-3834, OBRA '93 data collection form, for the rate year.

(4) "Rate year" means the 12-month period beginning on October 1.

(c) Beginning July 1, 2012 and ending on December 31, 2026 ~~2022~~, a hospital that would have qualified for the rate year beginning October 1, 2011 or October 1, 2012 shall be a Safety-Net Hospital.

(c-5) Beginning July 1, 2020 and ending on December 31, 2026, a hospital that would have qualified for the rate year beginning October 1, 2020 and was designated a federal rural referral center under 42 CFR 412.96 as of October 1, 2020 shall be a Safety-Net Hospital.

(d) No later than August 15 preceding the rate year, each hospital shall submit the OBRA form to the Department. Prior to October 1, the Department shall notify each hospital whether it has qualified as a Safety-Net Hospital.

(e) The Department may promulgate rules in order to implement this Section.

(f) Nothing in this Section shall be construed as limiting the ability of the Department to include the Safety-Net Hospitals in the hospital rate reform mandated by Section 14-11 of this Code and implemented under Section 14-12 of this Code and by administrative rulemaking.

(Source: P.A. 100-581, eff. 3-12-18; 101-650, eff. 7-7-20; 101-669, eff. 4-2-21.)

1 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)
2 (Section scheduled to be repealed on December 31, 2022)
3 Sec. 5A-2. Assessment.
4 (a)(1) Subject to Sections 5A-3 and 5A-10, for State
5 fiscal years 2009 through 2018, or as long as continued under
6 Section 5A-16, an annual assessment on inpatient services is
7 imposed on each hospital provider in an amount equal to
8 $218.38 multiplied by the difference of the hospital's
9 occupied bed days less the hospital's Medicare bed days,
10 provided, however, that the amount of $218.38 shall be
11 increased by a uniform percentage to generate an amount equal
12 to 75% of the State share of the payments authorized under
13 Section 5A-12.5, with such increase only taking effect upon
14 the date that a State share for such payments is required under
15 federal law. For the period of April through June 2015, the
16 amount of $218.38 used to calculate the assessment under this
17 paragraph shall, by emergency rule under subsection (s) of
18 Section 5-45 of the Illinois Administrative Procedure Act, be
19 increased by a uniform percentage to generate $20,250,000 in
20 the aggregate for that period from all hospitals subject to
21 the annual assessment under this paragraph.
22 (2) In addition to any other assessments imposed under
23 this Article, effective July 1, 2016 and semi-annually
24 thereafter through June 2018, or as provided in Section 5A-16,
25 in addition to any federally required State share as

1 authorized under paragraph (1), the amount of $218.38 shall be
2 increased by a uniform percentage to generate an amount equal
3 to 75% of the ACA Assessment Adjustment, as defined in
4 subsection (b-6) of this Section.

5 For State fiscal years 2009 through 2018, or as provided
6 in Section 5A-16, a hospital's occupied bed days and Medicare
7 bed days shall be determined using the most recent data
8 available from each hospital's 2005 Medicare cost report as
9 contained in the Healthcare Cost Report Information System
10 file, for the quarter ending on December 31, 2006, without
11 regard to any subsequent adjustments or changes to such data.
12 If a hospital's 2005 Medicare cost report is not contained in
13 the Healthcare Cost Report Information System, then the
14 Illinois Department may obtain the hospital provider's
15 occupied bed days and Medicare bed days from any source
16 available, including, but not limited to, records maintained
17 by the hospital provider, which may be inspected at all times
18 during business hours of the day by the Illinois Department or
19 its duly authorized agents and employees.

20 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
21 fiscal years 2019 and 2020, an annual assessment on inpatient
22 services is imposed on each hospital provider in an amount
23 equal to $197.19 multiplied by the difference of the
24 hospital's occupied bed days less the hospital's Medicare bed
25 days. For State fiscal years 2019 and 2020, a hospital's
26 occupied bed days and Medicare bed days shall be determined

using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 <u>and to subsection (b-8)</u>, for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 <u>through 2026</u> ~~and 2022~~, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however: for the period of July 1, 2020 through December 31, 2020, (i) the assessment shall be equal to 50% of the annual amount; and (ii) the amount

of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026 ~~and 2022~~, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology for fiscal years 2021 through December 31, 2022 not be approved on or before June 30, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the assessment methodology for July 1, 2020 through December 31, 2022, is approved on or after July 1, 2020, it shall be retroactive to July 1, 2020, subject to federal approval and provided that the payments authorized

1 under Section 5A-12.7 have the same effective date as the new
2 assessment methodology. In giving retroactive effect to the
3 assessment approved after June 30, 2020, credit toward the new
4 assessment shall be given for any payments of the previous
5 assessment for periods after June 30, 2020. Notwithstanding
6 any other provision of this Article, for a hospital provider
7 that did not have a 2015 Medicare cost report, but paid an
8 assessment in State Fiscal Year 2020 on the basis of
9 hypothetical data, the data that was the basis for the 2020
10 assessment shall be used to calculate the assessment under
11 this paragraph until December 31, 2023. Beginning July 1, 2022
12 and through December 31, 2024, a safety-net hospital that had
13 a change of ownership in calendar year 2021, and whose
14 inpatient utilization had decreased by 90% from the prior year
15 and prior to the change of ownership, may be eligible to pay a
16 tax based on hypothetical data based on a determination of
17 financial distress by the Department.

18 (b) (Blank).

19 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
20 portion of State fiscal year 2012, beginning June 10, 2012
21 through June 30, 2012, and for State fiscal years 2013 through
22 2018, or as provided in Section 5A-16, an annual assessment on
23 outpatient services is imposed on each hospital provider in an
24 amount equal to .008766 multiplied by the hospital's
25 outpatient gross revenue, provided, however, that the amount
26 of .008766 shall be increased by a uniform percentage to

1 generate an amount equal to 25% of the State share of the
2 payments authorized under Section 5A-12.5, with such increase
3 only taking effect upon the date that a State share for such
4 payments is required under federal law. For the period
5 beginning June 10, 2012 through June 30, 2012, the annual
6 assessment on outpatient services shall be prorated by
7 multiplying the assessment amount by a fraction, the numerator
8 of which is 21 days and the denominator of which is 365 days.
9 For the period of April through June 2015, the amount of
10 .008766 used to calculate the assessment under this paragraph
11 shall, by emergency rule under subsection (s) of Section 5-45
12 of the Illinois Administrative Procedure Act, be increased by
13 a uniform percentage to generate $6,750,000 in the aggregate
14 for that period from all hospitals subject to the annual
15 assessment under this paragraph.

16 (2) In addition to any other assessments imposed under
17 this Article, effective July 1, 2016 and semi-annually
18 thereafter through June 2018, in addition to any federally
19 required State share as authorized under paragraph (1), the
20 amount of .008766 shall be increased by a uniform percentage
21 to generate an amount equal to 25% of the ACA Assessment
22 Adjustment, as defined in subsection (b-6) of this Section.

23 For the portion of State fiscal year 2012, beginning June
24 10, 2012 through June 30, 2012, and State fiscal years 2013
25 through 2018, or as provided in Section 5A-16, a hospital's
26 outpatient gross revenue shall be determined using the most

1 recent data available from each hospital's 2009 Medicare cost
2 report as contained in the Healthcare Cost Report Information
3 System file, for the quarter ending on June 30, 2011, without
4 regard to any subsequent adjustments or changes to such data.
5 If a hospital's 2009 Medicare cost report is not contained in
6 the Healthcare Cost Report Information System, then the
7 Department may obtain the hospital provider's outpatient gross
8 revenue from any source available, including, but not limited
9 to, records maintained by the hospital provider, which may be
10 inspected at all times during business hours of the day by the
11 Department or its duly authorized agents and employees.
12 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
13 fiscal years 2019 and 2020, an annual assessment on outpatient
14 services is imposed on each hospital provider in an amount
15 equal to .01358 multiplied by the hospital's outpatient gross
16 revenue. For State fiscal years 2019 and 2020, a hospital's
17 outpatient gross revenue shall be determined using the most
18 recent data available from each hospital's 2015 Medicare cost
19 report as contained in the Healthcare Cost Report Information
20 System file, for the quarter ending on March 31, 2017, without
21 regard to any subsequent adjustments or changes to such data.
22 If a hospital's 2015 Medicare cost report is not contained in
23 the Healthcare Cost Report Information System, then the
24 Department may obtain the hospital provider's outpatient gross
25 revenue from any source available, including, but not limited
26 to, records maintained by the hospital provider, which may be

inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026 ~~and 2022~~, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however: (i) for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount; and (ii) the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026 ~~and 2022~~, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the

Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology above for fiscal years 2021 through calendar year 2022 not be approved prior to July 1, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the change in the assessment methodology above for July 1, 2020 through December 31, 2022, is approved after June 30, 2020, it shall have a retroactive effective date of July 1, 2020, subject to federal approval and provided that the payments authorized under Section 12A-7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022

and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department.

(b-6)(1) As used in this Section, "ACA Assessment Adjustment" means:

(A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016

1 through December 31, 2016 and the estimated payments due
2 and payable in the month of April 2016 multiplied by 6 as
3 described in subparagraph (A).
4 (C) For the period of July 1, 2017 through December
5 31, 2017, the product of .19125 multiplied by the sum of
6 the fee-for-service payments to hospitals as authorized
7 under Section 5A-12.5 and the adjustments authorized under
8 subsection (t) of Section 5A-12.2 to managed care
9 organizations for hospital services due and payable in the
10 month of April 2017 multiplied by 6, except that the
11 amount calculated under this subparagraph (C) shall be
12 adjusted, either positively or negatively, to account for
13 the difference between the actual payments issued under
14 Section 5A-12.5 for the period beginning January 1, 2017
15 through June 30, 2017 and the estimated payments due and
16 payable in the month of October 2016 multiplied by 6 as
17 described in subparagraph (B).
18 (D) For the period of January 1, 2018 through June 30,
19 2018, the product of .19125 multiplied by the sum of the
20 fee-for-service payments to hospitals as authorized under
21 Section 5A-12.5 and the adjustments authorized under
22 subsection (t) of Section 5A-12.2 to managed care
23 organizations for hospital services due and payable in the
24 month of October 2017 multiplied by 6, except that:
25 (i) the amount calculated under this subparagraph
26 (D) shall be adjusted, either positively or

1 negatively, to account for the difference between the
2 actual payments issued under Section 5A-12.5 for the
3 period of July 1, 2017 through December 31, 2017 and
4 the estimated payments due and payable in the month of
5 April 2017 multiplied by 6 as described in
6 subparagraph (C); and
7 (ii) the amount calculated under this subparagraph
8 (D) shall be adjusted to include the product of .19125
9 multiplied by the sum of the fee-for-service payments,
10 if any, estimated to be paid to hospitals under
11 subsection (b) of Section 5A-12.5.
12 (2) The Department shall complete and apply a final
13 reconciliation of the ACA Assessment Adjustment prior to June
14 30, 2018 to account for:
15 (A) any differences between the actual payments issued
16 or scheduled to be issued prior to June 30, 2018 as
17 authorized in Section 5A-12.5 for the period of January 1,
18 2018 through June 30, 2018 and the estimated payments due
19 and payable in the month of October 2017 multiplied by 6 as
20 described in subparagraph (D); and
21 (B) any difference between the estimated
22 fee-for-service payments under subsection (b) of Section
23 5A-12.5 and the amount of such payments that are actually
24 scheduled to be paid.
25 The Department shall notify hospitals of any additional
26 amounts owed or reduction credits to be applied to the June

2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(b-7)(1) As used in this Section, "Assessment Adjustment" means:

(A) For the period of July 1, 2020 through December

31, 2020, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(B) For each calendar quarter beginning ~~on and after~~ January 1, 2021 through December 31, 2022, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(C) Beginning on January 1, 2023, and each subsequent July 1 and January 1, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (j) of Section 5A-12.7 attributable to the 6-month period immediately preceding the period to which the adjustment applies, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the 6-month period immediately preceding the period to which the adjustment applies.

(2) The Department shall calculate and notify each hospital of the total Assessment Adjustment and any additional assessment owed by the hospital or refund owed to the hospital on either a semi-annual or annual basis. Such notice shall be issued at least 30 days prior to any period in which the

1 assessment will be adjusted. Any additional assessment owed by
2 the hospital or refund owed to the hospital shall be uniformly
3 applied to the assessment owed by the hospital in monthly
4 installments for the subsequent semi-annual period or calendar
5 year. If no assessment is owed in the subsequent year, any
6 amount owed by the hospital or refund due to the hospital,
7 shall be paid in a lump sum.

8 (3) The Department shall publish all details of the
9 Assessment Adjustment calculation performed each year on its
10 website within 30 days of completing the calculation, and also
11 submit the details of the Assessment Adjustment calculation as
12 part of the Department's annual report to the General
13 Assembly.

14 (b-8) Notwithstanding any other provision of this Article,
15 the Department shall reduce the assessments imposed on each
16 hospital under subsections (a) and (b-5) by the uniform
17 percentage necessary to reduce the total assessment imposed on
18 all hospitals by an aggregate amount of $240,000,000, with
19 such reduction being applied by June 30, 2022. The assessment
20 reduction required for each hospital under this subsection
21 shall be forever waived, forgiven, and released by the
22 Department.

23 (c) (Blank).

24 (d) Notwithstanding any of the other provisions of this
25 Section, the Department is authorized to adopt rules to reduce
26 the rate of any annual assessment imposed under this Section,

as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois

1 Administrative Procedure Act.
2 (Source: P.A. 100-581, eff. 3-12-18; 101-10, eff. 6-5-19;
3 101-650, eff. 7-7-20; reenacted by P.A. 101-655, eff.
4 3-12-21.)

5 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)
6 Sec. 5A-5. Notice; penalty; maintenance of records.
7 (a) The Illinois Department shall send a notice of
8 assessment to every hospital provider subject to assessment
9 under this Article. The notice of assessment shall notify the
10 hospital of its assessment and shall be sent after receipt by
11 the Department of notification from the Centers for Medicare
12 and Medicaid Services of the U.S. Department of Health and
13 Human Services that the payment methodologies required under
14 this Article and, if necessary, the waiver granted under 42
15 CFR 433.68 have been approved. The notice shall be on a form
16 prepared by the Illinois Department and shall state the
17 following:
18 (1) The name of the hospital provider.
19 (2) The address of the hospital provider's principal
20 place of business from which the provider engages in the
21 occupation of hospital provider in this State, and the
22 name and address of each hospital operated, conducted, or
23 maintained by the provider in this State.
24 (3) The occupied bed days, occupied bed days less
25 Medicare days, adjusted gross hospital revenue, or

1 outpatient gross revenue of the hospital provider
2 (whichever is applicable), the amount of assessment
3 imposed under Section 5A-2 for the State fiscal year for
4 which the notice is sent, and the amount of each
5 installment to be paid during the State fiscal year.
6 (4) (Blank).
7 (5) Other reasonable information as determined by the
8 Illinois Department.
9 (b) If a hospital provider conducts, operates, or
10 maintains more than one hospital licensed by the Illinois
11 Department of Public Health, the provider shall pay the
12 assessment for each hospital separately.
13 (c) Notwithstanding any other provision in this Article,
14 in the case of a person who ceases to conduct, operate, or
15 maintain a hospital in respect of which the person is subject
16 to assessment under this Article as a hospital provider, the
17 assessment for the State fiscal year in which the cessation
18 occurs shall be adjusted by multiplying the assessment
19 computed under Section 5A-2 by a fraction, the numerator of
20 which is the number of days in the year during which the
21 provider conducts, operates, or maintains the hospital and the
22 denominator of which is 365. Immediately upon ceasing to
23 conduct, operate, or maintain a hospital, the person shall pay
24 the assessment for the year as so adjusted (to the extent not
25 previously paid).
26 (d) Notwithstanding any other provision in this Article, a

provider who commences conducting, operating, or maintaining a hospital, upon notice by the Illinois Department, shall pay the assessment computed under Section 5A-2 and subsection (e) in installments on the due dates stated in the notice and on the regular installment due dates for the State fiscal year occurring after the due dates of the initial notice.

(e) Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2018, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2009, the assessment under subsection (b-5) of Section 5A-2 for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department.

Notwithstanding any other provision in this Article, beginning July 1, 2018 through December 31, 2026 ~~for State fiscal years 2019 through 2024~~, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in the year that is the basis of the calculation of the

assessment under this Article, the assessment under paragraph (3) of subsection (a) of Section 5A-2 for the State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020; however, for State fiscal year 2020, the assessment amount shall be increased by the proportion that it represents of the total annual assessment that is generated from all hospitals in order to generate $6,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

Notwithstanding any other provision in this Article, beginning July 1, 2018 through December 31, 2026 ~~for State fiscal years 2019 through 2024~~, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in the year that is the basis of the calculation of the assessment under this Article, the assessment under subsection (b-5) of Section 5A-2 for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that

1 assessment amount shall be used for State fiscal years 2019
2 and 2020; however, for State fiscal year 2020, the assessment
3 amount shall be increased by the proportion that it represents
4 of the total annual assessment that is generated from all
5 hospitals in order to generate $6,250,000 in the aggregate for
6 that period from all hospitals subject to the annual
7 assessment under this paragraph.
8 (f) Every hospital provider subject to assessment under
9 this Article shall keep sufficient records to permit the
10 determination of adjusted gross hospital revenue for the
11 hospital's fiscal year. All such records shall be kept in the
12 English language and shall, at all times during regular
13 business hours of the day, be subject to inspection by the
14 Illinois Department or its duly authorized agents and
15 employees.
16 (g) The Illinois Department may, by rule, provide a
17 hospital provider a reasonable opportunity to request a
18 clarification or correction of any clerical or computational
19 errors contained in the calculation of its assessment, but
20 such corrections shall not extend to updating the cost report
21 information used to calculate the assessment.
22 (h) (Blank).
23 (Source: P.A. 99-78, eff. 7-20-15; 100-581, eff. 3-12-18.)

24 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)
25 Sec. 5A-8. Hospital Provider Fund.

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

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

(1) For making payments to hospitals as required under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

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

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing activities under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

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

1 (5) For making transfers, as those transfers are
2 authorized in the proceedings authorizing debt under the
3 Short Term Borrowing Act, but transfers made under this
4 paragraph (5) shall not exceed the principal amount of
5 debt issued in anticipation of the receipt by the State of
6 moneys to be deposited into the Fund.
7 (6) For making transfers to any other fund in the
8 State treasury, but transfers made under this paragraph
9 (6) shall not exceed the amount transferred previously
10 from that other fund into the Hospital Provider Fund plus
11 any interest that would have been earned by that fund on
12 the monies that had been transferred.
13 (6.5) For making transfers to the Healthcare Provider
14 Relief Fund, except that transfers made under this
15 paragraph (6.5) shall not exceed $60,000,000 in the
16 aggregate.
17 (7) For making transfers not exceeding the following
18 amounts, related to State fiscal years 2013 through 2018,
19 to the following designated funds:
20 Health and Human Services Medicaid Trust
21 Fund $20,000,000
22 Long-Term Care Provider Fund $30,000,000
23 General Revenue Fund .... $80,000,000.
24 Transfers under this paragraph shall be made within 7 days
25 after the payments have been received pursuant to the
26 schedule of payments provided in subsection (a) of Section

5A-4.

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

(7.10) For State fiscal year 2014, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Healthcare Provider Relief Fund...... $100,000,000

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

The additional amount of transfers in this paragraph (7.10), authorized by Public Act 98-651, shall be made within 10 State business days after June 16, 2014 (the effective date of Public Act 98-651). That authority shall remain in effect even if Public Act 98-651 does not become law until State fiscal year 2015.

(7.10a) For State fiscal years 2015 through 2018, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and

1 received from hospital providers under Section 5A-4 and
2 transferred into the Hospital Provider Fund under Section
3 5A-6 to the designated funds not exceeding the following
4 amounts related to each State fiscal year:
5 Healthcare Provider Relief Fund...... $50,000,000
6 Transfers under this paragraph shall be made within 7
7 days after the payments have been received pursuant to the
8 schedule of payments provided in subsection (a) of Section
9 5A-4.
10 (7.11) (Blank).
11 (7.12) For State fiscal year 2013, for increasing by
12 21/365ths the transfer of the moneys resulting from the
13 assessment under subsection (b-5) of Section 5A-2 and
14 received from hospital providers under Section 5A-4 for
15 the portion of State fiscal year 2012 beginning June 10,
16 2012 through June 30, 2012 and transferred into the
17 Hospital Provider Fund under Section 5A-6 to the
18 designated funds not exceeding the following amounts in
19 that State fiscal year:
20 Healthcare Provider Relief Fund........ $2,870,000
21 Since the federal Centers for Medicare and Medicaid
22 Services approval of the assessment authorized under
23 subsection (b-5) of Section 5A-2, received from hospital
24 providers under Section 5A-4 and the payment methodologies
25 to hospitals required under Section 5A-12.4 was not
26 received by the Department until State fiscal year 2014

1 and since the Department made retroactive payments during
2 State fiscal year 2014 related to the referenced period of
3 June 2012, the transfer authority granted in this
4 paragraph (7.12) is extended through the date that is 10
5 State business days after June 16, 2014 (the effective
6 date of Public Act 98-651).
7 (7.13) In addition to any other transfers authorized
8 under this Section, for State fiscal years 2017 and 2018,
9 for making transfers to the Healthcare Provider Relief
10 Fund of moneys collected from the ACA Assessment
11 Adjustment authorized under subsections (a) and (b-5) of
12 Section 5A-2 and paid by hospital providers under Section
13 5A-4 into the Hospital Provider Fund under Section 5A-6
14 for each State fiscal year. Timing of transfers to the
15 Healthcare Provider Relief Fund under this paragraph shall
16 be at the discretion of the Department, but no less
17 frequently than quarterly.
18 (7.14) For making transfers not exceeding the
19 following amounts, related to State fiscal years 2019 and
20 2020, to the following designated funds:
21 Health and Human Services Medicaid Trust
22 Fund $20,000,000
23 Long-Term Care Provider Fund $30,000,000
24 Healthcare Provider Relief Fund .... $325,000,000.
25 Transfers under this paragraph shall be made within 7
26 days after the payments have been received pursuant to the

schedule of payments provided in subsection (a) of Section 5A-4.

(7.15) For making transfers not exceeding the following amounts, related to State fiscal years 2023 through 2026 ~~2021 and 2022~~, to the following designated funds:

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

Healthcare Provider Relief Fund...... $365,000,000

(7.16) For making transfers not exceeding the following amounts, related to July 1, 2026 ~~2022~~ to December 31, 2026 ~~2022~~, to the following designated funds:

Health and Human Services Medicaid Trust Fund $10,000,000

Long-Term Care Provider Fund $15,000,000

Healthcare Provider Relief Fund...... $182,500,000

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

(9) For making payment to capitated managed care organizations as described in subsections (s) and (t) of Section 5A-12.2, subsection (r) of Section 5A-12.6, and Section 5A-12.7 of this Code.

Disbursements from the Fund, other than transfers authorized under paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon

1 receipt of vouchers duly executed and certified by the
2 Illinois Department.
3 (c) The Fund shall consist of the following:
4 (1) All moneys collected or received by the Illinois
5 Department from the hospital provider assessment imposed
6 by this Article.
7 (2) All federal matching funds received by the
8 Illinois Department as a result of expenditures made by
9 the Illinois Department that are attributable to moneys
10 deposited in the Fund.
11 (3) Any interest or penalty levied in conjunction with
12 the administration of this Article.
13 (3.5) As applicable, proceeds from surety bond
14 payments payable to the Department as referenced in
15 subsection (s) of Section 5A-12.2 of this Code.
16 (4) Moneys transferred from another fund in the State
17 treasury.
18 (5) All other moneys received for the Fund from any
19 other source, including interest earned thereon.
20 (d) (Blank).
21 (Source: P.A. 100-581, eff. 3-12-18; 100-863, eff. 8-14-19;
22 101-650, eff. 7-7-20.)

23 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)
24 Sec. 5A-10. Applicability.
25 (a) The assessment imposed by subsection (a) of Section

5A-2 shall cease to be imposed and the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The payments to hospitals required under this Article are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act;

(2) For State fiscal years 2009 through 2018, and as provided in Section 5A-16, the Department of Healthcare and Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

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

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

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

(D) in relation to any admissions on or after January 1, 2011, a modification in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, for hospitals reimbursed under the diagnosis-related grouping methodology in

effect on July 1, 2011; provided that the Department shall be limited to one such modification during the 36-month period after the effective date of this amendatory Act of the 96th General Assembly;

(E) any changes affecting hospitals authorized by Public Act 97-689;

(F) any changes authorized by Section 14-12 of this Code, or for any changes authorized under Section 5A-15 of this Code; or

(G) any changes authorized under Section 5-5b.1.

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed, and the Department's obligation to make payments shall immediately cease, if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(c) The assessments imposed by subsection (b-5) of Section 5A-2 shall not take effect or shall cease to be imposed, the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by

1 them, if the payments to hospitals required under Section
2 5A-12.4 or Section 5A-12.6 are not eligible for federal
3 matching funds under Title XIX of the Social Security Act.
4 (d) The assessments imposed by Section 5A-2 shall not take
5 effect or shall cease to be imposed, the Department's
6 obligation to make payments shall immediately cease, and any
7 moneys remaining in the Fund shall be refunded to hospital
8 providers in proportion to the amounts paid by them, if:
9 (1) for State fiscal years 2013 through 2018, and as
10 provided in Section 5A-16, the Department reduces any
11 payment rates to hospitals as in effect on May 1, 2012, or
12 alters any payment methodology as in effect on May 1,
13 2012, that has the effect of reducing payment rates to
14 hospitals, except for any changes affecting hospitals
15 authorized in Public Act 97-689 and any changes authorized
16 by Section 14-12 of this Code, and except for any changes
17 authorized under Section 5A-15, and except for any changes
18 authorized under Section 5-5b.1;
19 (2) for State fiscal years 2013 through 2018, and as
20 provided in Section 5A-16, the Department reduces any
21 supplemental payments made to hospitals below the amounts
22 paid for services provided in State fiscal year 2011 as
23 implemented by administrative rules adopted and in effect
24 on or prior to June 30, 2011, except for any changes
25 affecting hospitals authorized in Public Act 97-689 and
26 any changes authorized by Section 14-12 of this Code, and

1 except for any changes authorized under Section 5A-15, and
2 except for any changes authorized under Section 5-5b.1; or
3 (3) for State fiscal years 2015 through 2018, and as
4 provided in Section 5A-16, the Department reduces the
5 overall effective rate of reimbursement to hospitals below
6 the level authorized under Section 14-12 of this Code,
7 except for any changes under Section 14-12 or Section
8 5A-15 of this Code, and except for any changes authorized
9 under Section 5-5b.1.
10 (e) In State fiscal year 2019 through State fiscal year
11 2020, the assessments imposed under Section 5A-2 shall not
12 take effect or shall cease to be imposed, the Department's
13 obligation to make payments shall immediately cease, and any
14 moneys remaining in the Fund shall be refunded to hospital
15 providers in proportion to the amounts paid by them, if:
16 (1) the payments to hospitals required under Section
17 5A-12.6 are not eligible for federal matching funds under
18 Title XIX of the Social Security Act; or
19 (2) the Department reduces the overall effective rate
20 of reimbursement to hospitals below the level authorized
21 under Section 14-12 of this Code, as in effect on December
22 31, 2017, except for any changes authorized under Sections
23 14-12 or Section 5A-15 of this Code, and except for any
24 changes authorized under changes to Sections 5A-12.2,
25 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by Public Act
26 100-581.

(f) Beginning in State Fiscal Year 2021, the assessments imposed under Section 5A-2 shall not take effect or shall cease to be imposed, the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) the payments to hospitals required under Section 5A-12.7 are not eligible for federal matching funds under Title XIX of the Social Security Act; or

(2) the Department reduces the overall effective rate of reimbursement to hospitals below the level authorized under Section 14-12, as in effect on December 31, 2021 ~~2019~~, except for any changes authorized under Sections 14-12 or 5A-15, and except for any changes authorized under changes to Sections 5A-12.7 and 14-12 made by this amendatory Act of the 101st General Assembly, and except for any changes to Section 5A-12.7 made by this amendatory Act of the 102nd General Assembly.

(Source: P.A. 100-581, eff. 3-12-18; 101-650, eff. 7-7-20.)

(305 ILCS 5/5A-12.7)

(Section scheduled to be repealed on December 31, 2022)

Sec. 5A-12.7. Continuation of hospital access payments on and after July 1, 2020.

(a) To preserve and improve access to hospital services, for hospital services rendered on and after July 1, 2020, the

Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals or require capitated managed care organizations to make payments as set forth in this Section. Payments under this Section are not due and payable, however, until: (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment or directed payment preprint; and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. In determining the hospital access payments authorized under subsection (g) of this Section, if a hospital ceases to qualify for payments from the pool, the payments for all hospitals continuing to qualify for payments from such pool shall be uniformly adjusted to fully expend the aggregate net amount of the pool, with such adjustment being effective on the first day of the second month following the date the hospital ceases to receive payments from such pool.

(b) Amounts moved into claims-based rates and distributed in accordance with Section 14-12 shall remain in those claims-based rates.

(c) Graduate medical education.

(1) The calculation of graduate medical education payments shall be based on the hospital's Medicare cost report ending in Calendar Year 2018, as reported in the Healthcare Cost Report Information System file, release date September 30, 2019. An Illinois hospital reporting

intern and resident cost on its Medicare cost report shall be eligible for graduate medical education payments.

(2) Each hospital's annualized Medicaid Intern Resident Cost is calculated using annualized intern and resident total costs obtained from Worksheet B Part I, Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93, 96-98, and 105-112 multiplied by the percentage that the hospital's Medicaid days (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of the hospital's total days (Worksheet S3 Part I, Column 8, Lines 14, 16-18, and 32).

(3) An annualized Medicaid indirect medical education (IME) payment is calculated for each hospital using its IME payments (Worksheet E Part A, Line 29, Column 1) multiplied by the percentage that its Medicaid days (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of its Medicare days (Worksheet S3 Part I, Column 6, Lines 2, 3, 4, 14, and 16-18).

(4) For each hospital, its annualized Medicaid Intern Resident Cost and its annualized Medicaid IME payment are summed, and, except as capped at 120% of the average cost per intern and resident for all qualifying hospitals as calculated under this paragraph, is multiplied by the applicable reimbursement factor as described in this paragraph, ~~22.6%~~ to determine the hospital's final graduate medical education payment. Each hospital's

average cost per intern and resident shall be calculated by summing its total annualized Medicaid Intern Resident Cost plus its annualized Medicaid IME payment and dividing that amount by the hospital's total Full Time Equivalent Residents and Interns. If the hospital's average per intern and resident cost is greater than 120% of the same calculation for all qualifying hospitals, the hospital's per intern and resident cost shall be capped at 120% of the average cost for all qualifying hospitals.

(A) For the period of July 1, 2020 through December 31, 2022, the applicable reimbursement factor shall be 22.6%.

(B) For the period of January 1, 2023 through December 31, 2026, the applicable reimbursement factor shall be 35% for all qualified safety-net hospitals, as defined in Section 5-5e.1 of this Code, and all hospitals with 100 or more Full Time Equivalent Residents and Interns, as reported on the hospital's Medicare cost report ending in Calendar Year 2018, and for all other qualified hospitals the applicable reimbursement factor shall be 30%.

(d) Fee-for-service supplemental payments. For the period of July 1, 2020 through December 31, 2022, each ~~Each~~ Illinois hospital shall receive an annual payment equal to the amounts below, to be paid in 12 equal installments on or before the seventh State business day of each month, except that no

payment shall be due within 30 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable.

(1) For critical access hospitals, $385 per covered inpatient day contained in paid fee-for-service claims and $530 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(2) For safety-net hospitals, $960 per covered inpatient day contained in paid fee-for-service claims and $625 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(3) For long term acute care hospitals, $295 per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(4) For freestanding psychiatric hospitals, $125 per covered inpatient day contained in paid fee-for-service claims and $130 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(5) For freestanding rehabilitation hospitals, $355

per covered inpatient day contained in paid fee-for-service claims for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of May 11, 2020.

(6) For all general acute care hospitals and high Medicaid hospitals as defined in subsection (f), $350 per covered inpatient day for dates of service in Calendar Year 2019 contained in paid fee-for-service claims and $620 per paid fee-for-service outpatient claim in the Department's Enterprise Data Warehouse as of May 11, 2020.

(7) Alzheimer's treatment access payment. Each Illinois academic medical center or teaching hospital, as defined in Section 5-5e.2 of this Code, that is identified as the primary hospital affiliate of one of the Regional Alzheimer's Disease Assistance Centers, as designated by the Alzheimer's Disease Assistance Act and identified in the Department of Public Health's Alzheimer's Disease State Plan dated December 2016, shall be paid an Alzheimer's treatment access payment equal to the product of the qualifying hospital's State Fiscal Year 2018 total inpatient fee-for-service days multiplied by the applicable Alzheimer's treatment rate of $226.30 for hospitals located in Cook County and $116.21 for hospitals located outside Cook County.

(d-2) Fee-for-service supplemental payments. Beginning January 1, 2023, each Illinois hospital shall receive an

annual payment equal to the amounts listed below, to be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 30 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. The Department may adjust the rates in paragraphs (1) through (7) to comply with the federal upper payment limits, with such adjustments being determined so that the total estimated spending by hospital class, under such adjusted rates, remains substantially similar to the total estimated spending under the original rates set forth in this subsection.

(1) For critical access hospitals, as defined in subsection (f), $750 per covered inpatient day contained in paid fee-for-service claims and $750 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of August 6, 2021.

(2) For safety-net hospitals, as described in subsection (f), $1,350 per inpatient day contained in paid fee-for-service claims and $1,350 per paid fee-for-service outpatient claim for dates of service in Calendar Year 2019 in the Department's Enterprise Data Warehouse as of August 6, 2021.

1 (3) For long term acute care hospitals, $550 per
2 covered inpatient day contained in paid fee-for-service
3 claims for dates of service in Calendar Year 2019 in the
4 Department's Enterprise Data Warehouse as of August 6,
5 2021.
6 (4) For freestanding psychiatric hospitals, $200 per
7 covered inpatient day contained in paid fee-for-service
8 claims and $200 per paid fee-for-service outpatient claim
9 for dates of service in Calendar Year 2019 in the
10 Department's Enterprise Data Warehouse as of August 6,
11 2021.
12 (5) For freestanding rehabilitation hospitals, $550
13 per covered inpatient day contained in paid
14 fee-for-service claims and $125 per paid fee-for-service
15 outpatient claim for dates of service in Calendar Year
16 2019 in the Department's Enterprise Data Warehouse as of
17 August 6, 2021.
18 (6) For all general acute care hospitals and high
19 Medicaid hospitals as defined in subsection (f), $500 per
20 covered inpatient day for dates of service in Calendar
21 Year 2019 contained in paid fee-for-service claims and
22 $500 per paid fee-for-service outpatient claim in the
23 Department's Enterprise Data Warehouse as of August 6,
24 2021.
25 (7) For public hospitals, as defined in subsection
26 (f), $275 per covered inpatient day contained in paid

1 fee-for-service claims and $275 per paid fee-for-service
2 outpatient claim for dates of service in Calendar Year
3 2019 in the Department's Enterprise Data Warehouse as of
4 August 6, 2021.
5 (8) Alzheimer's treatment access payment. Each
6 Illinois academic medical center or teaching hospital, as
7 defined in Section 5-5e.2 of this Code, that is identified
8 as the primary hospital affiliate of one of the Regional
9 Alzheimer's Disease Assistance Centers, as designated by
10 the Alzheimer's Disease Assistance Act and identified in
11 the Department of Public Health's Alzheimer's Disease
12 State Plan dated December 2016, shall be paid an
13 Alzheimer's treatment access payment equal to the product
14 of the qualifying hospital's Calendar Year 2019 total
15 inpatient fee-for-service days, in the Department's
16 Enterprise Data Warehouse as of August 6, 2021, multiplied
17 by the applicable Alzheimer's treatment rate of $244.37
18 for hospitals located in Cook County and $312.03 for
19 hospitals located outside Cook County.
20 (e) The Department shall require managed care
21 organizations (MCOs) to make directed payments and
22 pass-through payments according to this Section. Each calendar
23 year, the Department shall require MCOs to pay the maximum
24 amount out of these funds as allowed as pass-through payments
25 under federal regulations. The Department shall require MCOs
26 to make such pass-through payments as specified in this

1 Section. The Department shall require the MCOs to pay the
2 remaining amounts as directed Payments as specified in this
3 Section. The Department shall issue payments to the
4 Comptroller by the seventh business day of each month for all
5 MCOs that are sufficient for MCOs to make the directed
6 payments and pass-through payments according to this Section.
7 The Department shall require the MCOs to make pass-through
8 payments and directed payments using electronic funds
9 transfers (EFT), if the hospital provides the information
10 necessary to process such EFTs, in accordance with directions
11 provided monthly by the Department, within 7 business days of
12 the date the funds are paid to the MCOs, as indicated by the
13 "Paid Date" on the website of the Office of the Comptroller if
14 the funds are paid by EFT and the MCOs have received directed
15 payment instructions. If funds are not paid through the
16 Comptroller by EFT, payment must be made within 7 business
17 days of the date actually received by the MCO. The MCO will be
18 considered to have paid the pass-through payments when the
19 payment remittance number is generated or the date the MCO
20 sends the check to the hospital, if EFT information is not
21 supplied. If an MCO is late in paying a pass-through payment or
22 directed payment as required under this Section (including any
23 extensions granted by the Department), it shall pay a penalty,
24 unless waived by the Department for reasonable cause, to the
25 Department equal to 5% of the amount of the pass-through
26 payment or directed payment not paid on or before the due date

1 plus 5% of the portion thereof remaining unpaid on the last day
2 of each 30-day period thereafter. Payments to MCOs that would
3 be paid consistent with actuarial certification and enrollment
4 in the absence of the increased capitation payments under this
5 Section shall not be reduced as a consequence of payments made
6 under this subsection. The Department shall publish and
7 maintain on its website for a period of no less than 8 calendar
8 quarters, the quarterly calculation of directed payments and
9 pass-through payments owed to each hospital from each MCO. All
10 calculations and reports shall be posted no later than the
11 first day of the quarter for which the payments are to be
12 issued.

13 (f)(1) For purposes of allocating the funds included in
14 capitation payments to MCOs, Illinois hospitals shall be
15 divided into the following classes as defined in
16 administrative rules:

17 (A) Beginning July 1, 2020 through December 31, 2022,
18 critical ~~Critical~~ access hospitals. Beginning January 1,
19 2023, "critical access hospital" means a hospital
20 designated by the Department of Public Health as a
21 critical access hospital, excluding any hospital meeting
22 the definition of a public hospital in subparagraph (F).

23 (B) Safety-net hospitals, except that stand-alone
24 children's hospitals that are not specialty children's
25 hospitals will not be included. For the calendar year
26 beginning January 1, 2023, and each calendar year

1 thereafter, assignment to the safety-net class shall be
2 based on the annual safety-net rate year beginning 15
3 months before the beginning of the first Payout Quarter of
4 the calendar year.
5 (C) Long term acute care hospitals.
6 (D) Freestanding psychiatric hospitals.
7 (E) Freestanding rehabilitation hospitals.
8 (F) Beginning January 1, 2023, "public hospital" means
9 a hospital that is owned or operated by an Illinois
10 Government body or municipality, excluding a hospital
11 provider that is a State agency, a State university, or a
12 county with a population of 3,000,000 or more.
13 (G) ~~(F)~~ High Medicaid hospitals.
14 (i) As used in this Section, "high Medicaid
15 hospital" means a general acute care hospital that:
16 (I) For the payout periods July 1, 2020
17 through December 31, 2022, is not a safety-net
18 hospital or critical access hospital and that has
19 a Medicaid Inpatient Utilization Rate above 30% or
20 a hospital that had over 35,000 inpatient Medicaid
21 days during the applicable period. For the period
22 July 1, 2020 through December 31, 2020, the
23 applicable period for the Medicaid Inpatient
24 Utilization Rate (MIUR) is the rate year 2020 MIUR
25 and for the number of inpatient days it is State
26 fiscal year 2018. Beginning in calendar year 2021,

1 the Department shall use the most recently
2 determined MIUR, as defined in subsection (h) of
3 Section 5-5.02, and for the inpatient day
4 threshold, the State fiscal year ending 18 months
5 prior to the beginning of the calendar year. For
6 purposes of calculating MIUR under this Section,
7 children's hospitals and affiliated general acute
8 care hospitals shall be considered a single
9 hospital.
10 (II) For the calendar year beginning January
11 1, 2023, and each calendar year thereafter, is not
12 a public hospital, safety-net hospital, or
13 critical access hospital and that qualifies as a
14 regional high volume hospital or is a hospital
15 that has a Medicaid Inpatient Utilization Rate
16 (MIUR) above 30%. As used in this item, "regional
17 high volume hospital" means a hospital which ranks
18 in the top 2 quartiles based on total hospital
19 services volume, of all eligible general acute
20 care hospitals, when ranked in descending order
21 based on total hospital services volume, within
22 the same Medicaid managed care region, as
23 designated by the Department, as of January 1,
24 2022. As used in this item, "total hospital
25 services volume" means the total of all Medical
26 Assistance hospital inpatient admissions plus all

Medical Assistance hospital outpatient visits. For purposes of determining regional high volume hospital inpatient admissions and outpatient visits, the Department shall use dates of service provided during State Fiscal Year 2020 for the Payout Quarter beginning January 1, 2023. The Department shall use dates of service from the State fiscal year ending 18 month before the beginning of the first Payout Quarter of the subsequent annual determination period.

(ii) For the calendar year beginning January 1, 2023, the Department shall use the Rate Year 2022 Medicaid inpatient utilization rate (MIUR), as defined in subsection (h) of Section 5-5.02. For each subsequent annual determination, the Department shall use the MIUR applicable to the rate year ending September 30 of the year preceding the beginning of the calendar year.

(H) ~~(G)~~ General acute care hospitals. As used under this Section, "general acute care hospitals" means all other Illinois hospitals not identified in subparagraphs (A) through (G) ~~(F)~~.

(2) Hospitals' qualification for each class shall be assessed prior to the beginning of each calendar year and the new class designation shall be effective January 1 of the next year. The Department shall publish by rule the process for

establishing class determination.

(g) Fixed pool directed payments. Beginning July 1, 2020, the Department shall issue payments to MCOs which shall be used to issue directed payments to qualified Illinois safety-net hospitals and critical access hospitals on a monthly basis in accordance with this subsection. Prior to the beginning of each Payout Quarter beginning July 1, 2020, the Department shall use encounter claims data from the Determination Quarter, accepted by the Department's Medicaid Management Information System for inpatient and outpatient services rendered by safety-net hospitals and critical access hospitals to determine a quarterly uniform per unit add-on for each hospital class.

(1) Inpatient per unit add-on. A quarterly uniform per diem add-on shall be derived by dividing the quarterly Inpatient Directed Payments Pool amount allocated to the applicable hospital class by the total inpatient days contained on all encounter claims received during the Determination Quarter, for all hospitals in the class.

(A) Each hospital in the class shall have a quarterly inpatient directed payment calculated that is equal to the product of the number of inpatient days attributable to the hospital used in the calculation of the quarterly uniform class per diem add-on, multiplied by the calculated applicable quarterly uniform class per diem add-on of the hospital class.

1 (B) Each hospital shall be paid 1/3 of its
2 quarterly inpatient directed payment in each of the 3
3 months of the Payout Quarter, in accordance with
4 directions provided to each MCO by the Department.
5 (2) Outpatient per unit add-on. A quarterly uniform
6 per claim add-on shall be derived by dividing the
7 quarterly Outpatient Directed Payments Pool amount
8 allocated to the applicable hospital class by the total
9 outpatient encounter claims received during the
10 Determination Quarter, for all hospitals in the class.
11 (A) Each hospital in the class shall have a
12 quarterly outpatient directed payment calculated that
13 is equal to the product of the number of outpatient
14 encounter claims attributable to the hospital used in
15 the calculation of the quarterly uniform class per
16 claim add-on, multiplied by the calculated applicable
17 quarterly uniform class per claim add-on of the
18 hospital class.
19 (B) Each hospital shall be paid 1/3 of its
20 quarterly outpatient directed payment in each of the 3
21 months of the Payout Quarter, in accordance with
22 directions provided to each MCO by the Department.
23 (3) Each MCO shall pay each hospital the Monthly
24 Directed Payment as identified by the Department on its
25 quarterly determination report.
26 (4) Definitions. As used in this subsection:

1 (A) "Payout Quarter" means each 3 month calendar
2 quarter, beginning July 1, 2020.
3 (B) "Determination Quarter" means each 3 month
4 calendar quarter, which ends 3 months prior to the
5 first day of each Payout Quarter.
6 (5) For the period July 1, 2020 through December 2020,
7 the following amounts shall be allocated to the following
8 hospital class directed payment pools for the quarterly
9 development of a uniform per unit add-on:
10 (A) $2,894,500 for hospital inpatient services for
11 critical access hospitals.
12 (B) $4,294,374 for hospital outpatient services
13 for critical access hospitals.
14 (C) $29,109,330 for hospital inpatient services
15 for safety-net hospitals.
16 (D) $35,041,218 for hospital outpatient services
17 for safety-net hospitals.
18 (6) For the period January 1, 2023 through December
19 31, 2023, the Department shall establish the amounts that
20 shall be allocated to the hospital class directed payment
21 fixed pools identified in this paragraph for the quarterly
22 development of a uniform per unit add-on. The Department
23 shall establish such amounts so that the total amount of
24 payments to each hospital under this Section in calendar
25 year 2023 is projected to be substantially similar to the
26 total amount of such payments received by the hospital

1 under this Section in calendar year 2021, adjusted for
2 increased funding provided for fixed pool directed
3 payments under subsection (g) in calendar year 2022,
4 assuming that the volume and acuity of claims are held
5 constant. The Department shall publish the directed
6 payment fixed pool amounts to be established under this
7 paragraph on its website by November 15, 2022.

8 (A) Hospital inpatient services for critical
9 access hospitals.

10 (B) Hospital outpatient services for critical
11 access hospitals.

12 (C) Hospital inpatient services for public
13 hospitals.

14 (D) Hospital outpatient services for public
15 hospitals.

16 (E) Hospital inpatient services for safety-net
17 hospitals.

18 (F) Hospital outpatient services for safety-net
19 hospitals.

20 (7) Semi-annual rate maintenance review. The
21 Department shall ensure that hospitals assigned to the
22 fixed pools in paragraph (6) are paid no less than 95% of
23 the annual initial rate for each 6-month period of each
24 annual payout period. For each calendar year, the
25 Department shall calculate the annual initial rate per day
26 and per visit for each fixed pool hospital class listed in

1 paragraph (6), by dividing the total of all applicable
2 inpatient or outpatient directed payments issued in the
3 preceding calendar year to the hospitals in each fixed
4 pool class for the calendar year, plus any increase
5 resulting from the annual adjustments described in
6 subsection (i), by the actual applicable total service
7 units for the preceding calendar year which were the basis
8 of the total applicable inpatient or outpatient directed
9 payments issued to the hospitals in each fixed pool class
10 in the calendar year, except that for calendar year 2023,
11 the service units from calendar year 2021 shall be used.
12 (A) The Department shall calculate the effective
13 rate, per day and per visit, for the payout periods of
14 January to June and July to December of each year, for
15 each fixed pool listed in paragraph (6), by dividing
16 50% of the annual pool by the total applicable
17 reported service units for the 2 applicable
18 determination quarters.
19 (B) If the effective rate calculated in
20 subparagraph (A) is less than 95% of the annual
21 initial rate assigned to the class for each pool under
22 paragraph (6), the Department shall adjust the payment
23 for each hospital to a level equal to no less than 95%
24 of the annual initial rate, by issuing a retroactive
25 adjustment payment for the 6-month period under review
26 as identified in subparagraph (A).

1 (h) Fixed rate directed payments. Effective July 1, 2020,
2 the Department shall issue payments to MCOs which shall be
3 used to issue directed payments to Illinois hospitals not
4 identified in paragraph (g) on a monthly basis. Prior to the
5 beginning of each Payout Quarter beginning July 1, 2020, the
6 Department shall use encounter claims data from the
7 Determination Quarter, accepted by the Department's Medicaid
8 Management Information System for inpatient and outpatient
9 services rendered by hospitals in each hospital class
10 identified in paragraph (f) and not identified in paragraph
11 (g). For the period July 1, 2020 through December 2020, the
12 Department shall direct MCOs to make payments as follows:
13 (1) For general acute care hospitals an amount equal
14 to $1,750 multiplied by the hospital's category of service
15 20 case mix index for the determination quarter multiplied
16 by the hospital's total number of inpatient admissions for
17 category of service 20 for the determination quarter.
18 (2) For general acute care hospitals an amount equal
19 to $160 multiplied by the hospital's category of service
20 21 case mix index for the determination quarter multiplied
21 by the hospital's total number of inpatient admissions for
22 category of service 21 for the determination quarter.
23 (3) For general acute care hospitals an amount equal
24 to $80 multiplied by the hospital's category of service 22
25 case mix index for the determination quarter multiplied by
26 the hospital's total number of inpatient admissions for

1 category of service 22 for the determination quarter.
2 (4) For general acute care hospitals an amount equal
3 to $375 multiplied by the hospital's category of service
4 24 case mix index for the determination quarter multiplied
5 by the hospital's total number of category of service 24
6 paid EAPG (EAPGs) for the determination quarter.
7 (5) For general acute care hospitals an amount equal
8 to $240 multiplied by the hospital's category of service
9 27 and 28 case mix index for the determination quarter
10 multiplied by the hospital's total number of category of
11 service 27 and 28 paid EAPGs for the determination
12 quarter.
13 (6) For general acute care hospitals an amount equal
14 to $290 multiplied by the hospital's category of service
15 29 case mix index for the determination quarter multiplied
16 by the hospital's total number of category of service 29
17 paid EAPGs for the determination quarter.
18 (7) For high Medicaid hospitals an amount equal to
19 $1,800 multiplied by the hospital's category of service 20
20 case mix index for the determination quarter multiplied by
21 the hospital's total number of inpatient admissions for
22 category of service 20 for the determination quarter.
23 (8) For high Medicaid hospitals an amount equal to
24 $160 multiplied by the hospital's category of service 21
25 case mix index for the determination quarter multiplied by
26 the hospital's total number of inpatient admissions for

1 category of service 21 for the determination quarter.
2 (9) For high Medicaid hospitals an amount equal to $80
3 multiplied by the hospital's category of service 22 case
4 mix index for the determination quarter multiplied by the
5 hospital's total number of inpatient admissions for
6 category of service 22 for the determination quarter.
7 (10) For high Medicaid hospitals an amount equal to
8 $400 multiplied by the hospital's category of service 24
9 case mix index for the determination quarter multiplied by
10 the hospital's total number of category of service 24 paid
11 EAPG outpatient claims for the determination quarter.
12 (11) For high Medicaid hospitals an amount equal to
13 $240 multiplied by the hospital's category of service 27
14 and 28 case mix index for the determination quarter
15 multiplied by the hospital's total number of category of
16 service 27 and 28 paid EAPGs for the determination
17 quarter.
18 (12) For high Medicaid hospitals an amount equal to
19 $290 multiplied by the hospital's category of service 29
20 case mix index for the determination quarter multiplied by
21 the hospital's total number of category of service 29 paid
22 EAPGs for the determination quarter.
23 (13) For long term acute care hospitals the amount of
24 $495 multiplied by the hospital's total number of
25 inpatient days for the determination quarter.
26 (14) For psychiatric hospitals the amount of $210

multiplied by the hospital's total number of inpatient days for category of service 21 for the determination quarter.

(15) For psychiatric hospitals the amount of $250 multiplied by the hospital's total number of outpatient claims for category of service 27 and 28 for the determination quarter.

(16) For rehabilitation hospitals the amount of $410 multiplied by the hospital's total number of inpatient days for category of service 22 for the determination quarter.

(17) For rehabilitation hospitals the amount of $100 multiplied by the hospital's total number of outpatient claims for category of service 29 for the determination quarter.

(18) Effective for the Payout Quarter beginning January 1, 2023, for the directed payments to hospitals required under this subsection, the Department shall establish the amounts that shall be used to calculate such directed payments using the methodologies specified in this paragraph. The Department shall use a single, uniform rate, adjusted for acuity as specified in paragraphs (1) through (12), for all categories of inpatient services provided by each class of hospitals and a single uniform rate, adjusted for acuity as specified in paragraphs (1) through (12), for all categories of outpatient services

provided by each class of hospitals. The Department shall establish such amounts so that the total amount of payments to each hospital under this Section in calendar year 2023 is projected to be substantially similar to the total amount of such payments received by the hospital under this Section in calendar year 2021, adjusted for increased funding provided for fixed pool directed payments under subsection (g) in calendar year 2022, assuming that the volume and acuity of claims are held constant. The Department shall publish the directed payment amounts to be established under this subsection on its website by November 15, 2022.

(19) ~~(18)~~ Each hospital shall be paid 1/3 of their quarterly inpatient and outpatient directed payment in each of the 3 months of the Payout Quarter, in accordance with directions provided to each MCO by the Department.

20 ~~(19)~~ Each MCO shall pay each hospital the Monthly Directed Payment amount as identified by the Department on its quarterly determination report.

Notwithstanding any other provision of this subsection, if the Department determines that the actual total hospital utilization data that is used to calculate the fixed rate directed payments is substantially different than anticipated when the rates in this subsection were initially determined ~~(~~for unforeseeable circumstances (such as the COVID-19 pandemic or some other public health emergency), the

Department may adjust the rates specified in this subsection so that the total directed payments approximate the total spending amount anticipated when the rates were initially established.

Definitions. As used in this subsection:

(A) "Payout Quarter" means each calendar quarter, beginning July 1, 2020.

(B) "Determination Quarter" means each calendar quarter which ends 3 months prior to the first day of each Payout Quarter.

(C) "Case mix index" means a hospital specific calculation. For inpatient claims the case mix index is calculated each quarter by summing the relative weight of all inpatient Diagnosis-Related Group (DRG) claims for a category of service in the applicable Determination Quarter and dividing the sum by the number of sum total of all inpatient DRG admissions for the category of service for the associated claims. The case mix index for outpatient claims is calculated each quarter by summing the relative weight of all paid EAPGs in the applicable Determination Quarter and dividing the sum by the sum total of paid EAPGs for the associated claims.

(i) Beginning January 1, 2021, the rates for directed payments shall be recalculated in order to spend the additional funds for directed payments that result from

reduction in the amount of pass-through payments allowed under federal regulations. The additional funds for directed payments shall be allocated proportionally to each class of hospitals based on that class' proportion of services.

(1) Beginning January 1, 2024, the fixed pool directed payment amounts and the associated annual initial rates referenced in paragraph (6) of subsection (f) for each hospital class shall be uniformly increased by a ratio of not less than, the ratio of the total pass-through reduction amount pursuant to paragraph (4) of subsection (j), for the hospitals comprising the hospital fixed pool directed payment class for the next calendar year, to the total inpatient and outpatient directed payments for the hospitals comprising the hospital fixed pool directed payment class paid during the preceding calendar year.

(2) Beginning January 1, 2024, the fixed rates for the directed payments referenced in paragraph (18) of subsection (h) for each hospital class shall be uniformly increased by a ratio of not less than, the ratio of the total pass-through reduction amount pursuant to paragraph (4) of subsection (j), for the hospitals comprising the hospital directed payment class for the next calendar year, to the total inpatient and outpatient directed payments for the hospitals comprising the hospital fixed rate directed payment class paid during the preceding calendar year.

(j) Pass-through payments.

(1) For the period July 1, 2020 through December 31, 2020, the Department shall assign quarterly pass-through payments to each class of hospitals equal to one-fourth of the following annual allocations:

(A) $390,487,095 to safety-net hospitals.

(B) $62,553,886 to critical access hospitals.

(C) $345,021,438 to high Medicaid hospitals.

(D) $551,429,071 to general acute care hospitals.

(E) $27,283,870 to long term acute care hospitals.

(F) $40,825,444 to freestanding psychiatric hospitals.

(G) $9,652,108 to freestanding rehabilitation hospitals.

(2) For the period of July 1, 2020 through December 31, 2020, the ~~The~~ pass-through payments shall at a minimum ensure hospitals receive a total amount of monthly payments under this Section as received in calendar year 2019 in accordance with this Article and paragraph (1) of subsection (d-5) of Section 14-12, exclusive of amounts received through payments referenced in subsection (b).

(3) For the calendar year beginning January 1, 2023, the Department shall establish the annual pass-through allocation to each class of hospitals and the pass-through payments to each hospital so that the total amount of payments to each hospital under this Section in calendar

1 year 2023 is projected to be substantially similar to the
2 total amount of such payments received by the hospital
3 under this Section in calendar year 2021, adjusted for
4 increased funding provided for fixed pool directed
5 payments under subsection (g) in calendar year 2022,
6 assuming that the volume and acuity of claims are held
7 constant. The Department shall publish the pass-through
8 allocation to each class and the pass-through payments to
9 each hospital to be established under this subsection on
10 its website by November 15, 2022.
11 (4) ~~(3)~~ For the calendar years ~~year~~ beginning January
12 1, 2021, January 1, 2022, and January 1, 2024, and each
13 calendar year thereafter, each hospital's pass-through
14 payment amount shall be reduced proportionally to the
15 reduction of all pass-through payments required by federal
16 regulations.
17 (k) At least 30 days prior to each calendar year, the
18 Department shall notify each hospital of changes to the
19 payment methodologies in this Section, including, but not
20 limited to, changes in the fixed rate directed payment rates,
21 the aggregate pass-through payment amount for all hospitals,
22 and the hospital's pass-through payment amount for the
23 upcoming calendar year.
24 (l) Notwithstanding any other provisions of this Section,
25 the Department may adopt rules to change the methodology for
26 directed and pass-through payments as set forth in this

Section, but only to the extent necessary to obtain federal approval of a necessary State Plan amendment or Directed Payment Preprint or to otherwise conform to federal law or federal regulation.

(m) As used in this subsection, "managed care organization" or "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis, excluding contracted entities for dual eligible or Department of Children and Family Services youth populations.

(n) In order to address the escalating infant mortality rates among minority communities in Illinois, the State shall, subject to appropriation, create a pool of funding of at least $50,000,000 annually to be disbursed among safety-net hospitals that maintain perinatal designation from the Department of Public Health. The funding shall be used to preserve or enhance OB/GYN services or other specialty services at the receiving hospital, with the distribution of funding to be established by rule and with consideration to perinatal hospitals with safe birthing levels and quality metrics for healthy mothers and babies.

(o) In order to address the growing challenges of providing stable access to healthcare in rural Illinois, including perinatal services, behavioral healthcare including substance use disorder services (SUDs) and other specialty services, and to expand access to telehealth services among

1 rural communities in Illinois, the Department of Healthcare
2 and Family Services, subject to appropriation, shall
3 administer a program to provide at least $10,000,000 in
4 financial support annually to critical access hospitals for
5 delivery of perinatal and OB/GYN services, behavioral
6 healthcare including SUDS, other specialty services and
7 telehealth services. The funding shall be used to preserve or
8 enhance perinatal and OB/GYN services, behavioral healthcare
9 including SUDS, other specialty services, as well as the
10 explanation of telehealth services by the receiving hospital,
11 with the distribution of funding to be established by rule.
12 (p) For calendar year 2023, the final amounts, rates, and
13 payments under subsections (c), (d-2), (g), (h), and (j) shall
14 be established by the Department, so that the sum of the total
15 estimated annual payments under subsections (c), (d-2), (g),
16 (h), and (j) for each hospital class for calendar year 2023, is
17 no less than:
18 (1) $858,260,000 to safety-net hospitals.
19 (2) $86,200,000 to critical access hospitals.
20 (3) $1,765,000,000 to high Medicaid hospitals.
21 (4) $673,860,000 to general acute care hospitals.
22 (5) $48,330,000 to long term acute care hospitals.
23 (6) $89,110,000 to freestanding psychiatric hospitals.
24 (7) $24,300,000 to freestanding rehabilitation
25 hospitals.
26 (8) $32,570,000 to public hospitals.

(Source: P.A. 101-650, eff. 7-7-20; 102-4, eff. 4-27-21; 102-16, eff. 6-17-21.)

(305 ILCS 5/5A-14)

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

(a) Section 5A-2 is repealed on December 31, <u>2026</u> ~~2022~~.

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

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

(d) Section 5A-12.2 and Section 5A-12.4 are repealed on July 1, 2018, subject to Section 5A-16.

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

(f) Section 5A-12.6 is repealed on July 1, 2020.

(g) Section 5A-12.7 is repealed on December 31, <u>2026</u> ~~2022~~.

(Source: P.A. 100-581, eff. 3-12-18; 101-650, eff. 7-7-20.)

ARTICLE 10.

Section 10-5. The Illinois Public Aid Code is amended by adding Section 5-45 as follows:

(305 ILCS 5/5-45 new)

<u>Sec. 5-45. General acute care hospitals. A general acute care hospital is authorized to file a notice with the Department of Public Health and the Health Facilities and Services Review Board to establish an acute mental illness category of service in accordance with the Illinois Health</u>

1 Facilities Planning Act and add authorized acute mental
2 illness beds if the following conditions are met:
3 (1) the general acute care hospital qualifies as a
4 safety-net hospital, as defined in Section 5-5e.1, as
5 determined by the Department of Healthcare and Family
6 Services at the time of filing the notice or for the year
7 immediately prior to the date of filing the notice;
8 (2) the notice seeks to establish no more than 24
9 authorized acute mental illness beds; and
10 (3) the notice seeks to reduce the number of
11 authorized beds in another category of service to offset
12 the number of authorized acute mental illness beds.

13 ARTICLE 15.

14 Section 15-5. The Illinois Public Aid Code is amended by
15 changing Section 12-4.105 as follows:

16 (305 ILCS 5/12-4.105)
17 Sec. 12-4.105. Human poison control center; payment
18 program. Subject to funding availability resulting from
19 transfers made from the Hospital Provider Fund to the
20 Healthcare Provider Relief Fund as authorized under this Code,
21 for State fiscal year 2017 and State fiscal year 2018, and for
22 each State fiscal year thereafter in which the assessment
23 under Section 5A-2 is imposed, the Department of Healthcare

1 and Family Services shall pay to the human poison control
2 center designated under the Poison Control System Act an
3 amount of not less than $3,000,000 for each of State fiscal
4 years 2017 through 2020, and for State fiscal years ~~year~~ 2021
5 through 2026 ~~and 2022~~ an amount of not less than $3,750,000 and
6 for the period July 1, 2026 ~~2022~~ through December 31, 2026 ~~2022~~
7 an amount of not less than $1,875,000, if the human poison
8 control center is in operation.
9 (Source: P.A. 100-581, eff. 3-12-18; 101-650, eff. 7-7-20.)

10 ARTICLE 20.

11 Section 20-5. The Department of Public Health Powers and
12 Duties Law is amended by adding Section 2310-710 as follows:

13 (20 ILCS 2310/2310-710 new)
14 Sec. 2310-710. Safety-Net Hospital Health Equity and
15 Access Leadership (HEAL) Grant Program.
16 (a) Findings. The General Assembly finds that there are
17 communities in Illinois that experience significant health
18 care disparities, as recently emphasized by the COVID-19
19 pandemic, aggravated by social determinants of health and a
20 lack of sufficient access to high quality healthcare
21 resources, particularly community-based services, preventive
22 care, obstetric care, chronic disease management, and
23 specialty care. Safety-net hospitals, as defined under the

1 Illinois Public Aid Code, serve as the anchors of the health
2 care system for many of these communities. Safety-net
3 hospitals not only care for their patients, they also are
4 rooted in their communities by providing jobs and partnering
5 with local organizations to help address the social
6 determinants of health, such as food, housing, and
7 transportation needs.
8 However, safety-net hospitals serve a significant number
9 of Medicare, Medicaid, and uninsured patients, and therefore,
10 are heavily dependent on underfunded government payers, and
11 are heavily burdened by uncompensated care. At the same time,
12 the overall cost of providing care has increased substantially
13 in recent years, driven by increasing costs for staffing,
14 prescription drugs, technology, and infrastructure.
15 For all of these reasons, the General Assembly finds that
16 the long term sustainability of safety-net hospitals is
17 threatened. While the General Assembly is providing funding to
18 the Department to be paid to support the expenses of specific
19 safety-net hospitals in State Fiscal Year 2023, such annual,
20 ad hoc funding is not a reliable and stable source of funding
21 that will enable safety-net hospitals to develop strategies to
22 achieve long term sustainability. Such annual, ad hoc funding
23 also does not provide the State with transparency and
24 accountability to ensure that such funding is being used
25 effectively and efficiently to maximize the benefit to members
26 of the community.

Therefore, it is the intent of the General Assembly that the Department of Public Health and the Department of Healthcare and Family Services jointly provide options and recommendations to the General Assembly by February 1, 2023, for the establishment of a permanent Safety-Net Hospital Health Equity and Access Leadership (HEAL) Grant Program, in accordance with this Section. It is the intention of the General Assembly that during State fiscal years 2024 through 2029, the Safety-Net Hospital Health Equity and Access Leadership (HEAL) Grant Program shall be supported by an annual funding pool of up to $100,000,000, subject to appropriation.

(b) By February 1, 2023, the Department of Public Health and the Department of Healthcare and Family Services shall provide a joint report to the General Assembly on options and recommendations for the establishment of a permanent Safety-Net Hospital Health Equity and Access Leadership (HEAL) Grant Program to be administered by the State. For this report, "safety-net hospital" means a hospital identified by the Department of Healthcare and Family Services under Section 5-5e.1 of the Illinois Public Aid Code. The Departments of Public Health and Healthcare and Family Services may consult with the statewide association representing a majority of hospitals and safety-net hospitals on the report. The report may include, but need not be limited to:

(1) Criteria for a safety-net hospital to be eligible

1 for the program, such as:
2 (A) The hospital is a participating provider in at
3 least one Medicaid managed care plan.
4 (B) The hospital is located in a medically
5 underserved area.
6 (C) The hospital's Medicaid utilization rate (for
7 both inpatient and outpatient services).
8 (D) The hospital's Medicare utilization rate (for
9 both inpatient and outpatient services).
10 (E) The hospital's uncompensated care percentage.
11 (F) The hospital's role in providing access to
12 services, reducing health disparities, and improving
13 health equity in its service area.
14 (G) The hospital's performance on quality
15 indicators.
16 (2) Potential projects eligible for grant funds which
17 may include projects to reduce health disparities, advance
18 health equity, or improve access to or the quality of
19 healthcare services.
20 (3) Potential policies, standards, and procedures to
21 ensure accountability for the use of grant funds.
22 (4) Potential strategies to generate federal Medicaid
23 matching funds for expenditures under the program.
24 (5) Potential policies, processes, and procedures for
25 the administration of the program.

ARTICLE 25.

Section 25-5. The Illinois Public Aid Code is amended by changing Section 5-5.02 as follows:

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

Sec. 5-5.02. Hospital reimbursements.

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

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

1 the Illinois Department on June 30, 1992.
2 (2) For the purpose of calculating the inpatient
3 payment rate for each hospital eligible to receive
4 quarterly adjustment payments for targeted access and
5 critical care, as defined by the Illinois Department on
6 June 30, 1992, the adjustment payment for the period July
7 1, 1992 through September 30, 1992, shall be 25% of the
8 annual adjustment payments calculated for each eligible
9 hospital, as of June 30, 1992. The Illinois Department
10 shall determine by rule the adjustment payments for
11 targeted access and critical care beginning October 1,
12 1992.
13 (3) For the purpose of calculating the inpatient
14 payment rate for each hospital eligible to receive
15 quarterly adjustment payments for uncompensated care, as
16 defined by the Illinois Department on June 30, 1992, the
17 adjustment payment for the period August 1, 1992 through
18 September 30, 1992, shall be one-sixth of the total
19 uncompensated care adjustment payments calculated for each
20 eligible hospital for the uncompensated care rate year, as
21 defined by the Illinois Department, ending on July 31,
22 1992. The Illinois Department shall determine by rule the
23 adjustment payments for uncompensated care beginning
24 October 1, 1992.
25 (b) Inpatient payments. For inpatient services provided on
26 or after October 1, 1993, in addition to rates paid for

1 hospital inpatient services pursuant to the Illinois Health
2 Finance Reform Act, as now or hereafter amended, or the
3 Illinois Department's prospective reimbursement methodology,
4 or any other methodology used by the Illinois Department for
5 inpatient services, the Illinois Department shall make
6 adjustment payments, in an amount calculated pursuant to the
7 methodology described in paragraph (c) of this Section, to
8 hospitals that the Illinois Department determines satisfy any
9 one of the following requirements:

10 (1) Hospitals that are described in Section 1923 of
11 the federal Social Security Act, as now or hereafter
12 amended, except that for rate year 2015 and after a
13 hospital described in Section 1923(b)(1)(B) of the federal
14 Social Security Act and qualified for the payments
15 described in subsection (c) of this Section for rate year
16 2014 provided the hospital continues to meet the
17 description in Section 1923(b)(1)(B) in the current
18 determination year; or

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

24 (3) Illinois hospitals that on July 1, 1991 had a
25 Medicaid inpatient utilization rate, as defined in
26 paragraph (h) of this Section, that was at least the mean

1 Medicaid inpatient utilization rate for all hospitals in
2 Illinois receiving Medicaid payments from the Illinois
3 Department and which were located in a planning area with
4 one-third or fewer excess beds as determined by the Health
5 Facilities and Services Review Board, and that, as of June
6 30, 1992, were located in a federally designated Health
7 Manpower Shortage Area; or
8 (4) Illinois hospitals that:
9 (A) have a Medicaid inpatient utilization rate
10 that is at least equal to the mean Medicaid inpatient
11 utilization rate for all hospitals in Illinois
12 receiving Medicaid payments from the Department; and
13 (B) also have a Medicaid obstetrical inpatient
14 utilization rate that is at least one standard
15 deviation above the mean Medicaid obstetrical
16 inpatient utilization rate for all hospitals in
17 Illinois receiving Medicaid payments from the
18 Department for obstetrical services; or
19 (5) Any children's hospital, which means a hospital
20 devoted exclusively to caring for children. A hospital
21 which includes a facility devoted exclusively to caring
22 for children shall be considered a children's hospital to
23 the degree that the hospital's Medicaid care is provided
24 to children if either (i) the facility devoted exclusively
25 to caring for children is separately licensed as a
26 hospital by a municipality prior to February 28, 2013;

(ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days as defined by the Department in rulemaking; (iii) the hospital has been designated as a Perinatal Level III center by the State as of December 1, 2017, is a Pediatric Critical Care Center designated by the State as of December 1, 2017 and has a 2017 Medicaid inpatient utilization rate equal to or greater than 45%; or (iv) the hospital has been designated as a Perinatal Level II center by the State as of December 1, 2017, has a 2017 Medicaid Inpatient Utilization Rate greater than 70%, and has at least 10 pediatric beds as listed on the IDPH 2015 calendar year hospital profile; or

(6) A hospital that reopens a previously closed hospital facility within 4 ~~3~~ calendar years of the hospital facility's closure, if the previously closed hospital facility qualified for payments under paragraph (c) at the time of closure, until utilization data for the new facility is available for the Medicaid inpatient utilization rate calculation. For purposes of this clause, a "closed hospital facility" shall include hospitals that have been terminated from participation in the medical assistance program in accordance with Section 12-4.25 of this Code.

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

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

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

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

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization

1 rate shall receive a per day adjustment payment equal to
2 the sum of $90 plus $2 for each one percent that the
3 hospital's Medicaid inpatient utilization rate exceeds 1.5
4 standard deviations above the mean Medicaid inpatient
5 utilization rate; and

6 (5) hospitals qualifying under clause (6) of paragraph
7 (b) shall have the rate assigned to the previously closed
8 hospital facility at the date of closure, until
9 utilization data for the new facility is available for the
10 Medicaid inpatient utilization rate calculation.

11 (d) Supplemental adjustment payments. In addition to the
12 adjustment payments described in paragraph (c), hospitals as
13 defined in clauses (1) through (6) of paragraph (b), excluding
14 county hospitals (as defined in subsection (c) of Section 15-1
15 of this Code) and a hospital organized under the University of
16 Illinois Hospital Act, shall be paid supplemental inpatient
17 adjustment payments of $60 per day. For purposes of Title XIX
18 of the federal Social Security Act, these supplemental
19 adjustment payments shall not be classified as adjustment
20 payments to disproportionate share hospitals.

21 (e) The inpatient adjustment payments described in
22 paragraphs (c) and (d) shall be increased on October 1, 1993
23 and annually thereafter by a percentage equal to the lesser of
24 (i) the increase in the DRI hospital cost index for the most
25 recent 12 month period for which data are available, or (ii)
26 the percentage increase in the statewide average hospital

1 payment rate over the previous year's statewide average
2 hospital payment rate. The sum of the inpatient adjustment
3 payments under paragraphs (c) and (d) to a hospital, other
4 than a county hospital (as defined in subsection (c) of
5 Section 15-1 of this Code) or a hospital organized under the
6 University of Illinois Hospital Act, however, shall not exceed
7 $275 per day; that limit shall be increased on October 1, 1993
8 and annually thereafter by a percentage equal to the lesser of
9 (i) the increase in the DRI hospital cost index for the most
10 recent 12-month period for which data are available or (ii)
11 the percentage increase in the statewide average hospital
12 payment rate over the previous year's statewide average
13 hospital payment rate.

14 (f) Children's hospital inpatient adjustment payments. For
15 children's hospitals, as defined in clause (5) of paragraph
16 (b), the adjustment payments required pursuant to paragraphs
17 (c) and (d) shall be multiplied by 2.0.

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

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

24 (1) "Medicaid inpatient utilization rate" means a
25 fraction, the numerator of which is the number of a
26 hospital's inpatient days provided in a given 12-month

1 period to patients who, for such days, were eligible for
2 Medicaid under Title XIX of the federal Social Security
3 Act, and the denominator of which is the total number of
4 the hospital's inpatient days in that same period.
5 (2) "Mean Medicaid inpatient utilization rate" means
6 the total number of Medicaid inpatient days provided by
7 all Illinois Medicaid-participating hospitals divided by
8 the total number of inpatient days provided by those same
9 hospitals.
10 (3) "Medicaid obstetrical inpatient utilization rate"
11 means the ratio of Medicaid obstetrical inpatient days to
12 total Medicaid inpatient days for all Illinois hospitals
13 receiving Medicaid payments from the Illinois Department.
14 (i) Inpatient adjustment payment limit. In order to meet
15 the limits of Public Law 102-234 and Public Law 103-66, the
16 Illinois Department shall by rule adjust disproportionate
17 share adjustment payments.
18 (j) University of Illinois Hospital inpatient adjustment
19 payments. For hospitals organized under the University of
20 Illinois Hospital Act, there shall be an adjustment payment as
21 determined by rules adopted by the Illinois Department.
22 (k) The Illinois Department may by rule establish criteria
23 for and develop methodologies for adjustment payments to
24 hospitals participating under this Article.
25 (l) On and after July 1, 2012, the Department shall reduce
26 any rate of reimbursement for services or other payments or

1 alter any methodologies authorized by this Code to reduce any
2 rate of reimbursement for services or other payments in
3 accordance with Section 5-5e.

4 (m) The Department shall establish a cost-based
5 reimbursement methodology for determining payments to
6 hospitals for approved graduate medical education (GME)
7 programs for dates of service on and after July 1, 2018.

8 (1) As used in this subsection, "hospitals" means the
9 University of Illinois Hospital as defined in the
10 University of Illinois Hospital Act and a county hospital
11 in a county of over 3,000,000 inhabitants.

12 (2) An amendment to the Illinois Title XIX State Plan
13 defining GME shall maximize reimbursement, shall not be
14 limited to the education programs or special patient care
15 payments allowed under Medicare, and shall include:

16 (A) inpatient days;

17 (B) outpatient days;

18 (C) direct costs;

19 (D) indirect costs;

20 (E) managed care days;

21 (F) all stages of medical training and education
22 including students, interns, residents, and fellows
23 with no caps on the number of persons who may qualify;
24 and

25 (G) patient care payments related to the
26 complexities of treating Medicaid enrollees including

1 clinical and social determinants of health.

2 (3) The Department shall make all GME payments
3 directly to hospitals including such costs in support of
4 clients enrolled in Medicaid managed care entities.

5 (4) The Department shall promptly take all actions
6 necessary for reimbursement to be effective for dates of
7 service on and after July 1, 2018 including publishing all
8 appropriate public notices, amendments to the Illinois
9 Title XIX State Plan, and adoption of administrative rules
10 if necessary.

11 (5) As used in this subsection, "managed care days"
12 means costs associated with services rendered to enrollees
13 of Medicaid managed care entities. "Medicaid managed care
14 entities" means any entity which contracts with the
15 Department to provide services paid for on a capitated
16 basis. "Medicaid managed care entities" includes a managed
17 care organization and a managed care community network.

18 (6) All payments under this Section are contingent
19 upon federal approval of changes to the Illinois Title XIX
20 State Plan, if that approval is required.

21 (7) The Department may adopt rules necessary to
22 implement Public Act 100-581 through the use of emergency
23 rulemaking in accordance with subsection (aa) of Section
24 5-45 of the Illinois Administrative Procedure Act. For
25 purposes of that Act, the General Assembly finds that the
26 adoption of rules to implement Public Act 100-581 is

deemed an emergency and necessary for the public interest, safety, and welfare.

(Source: P.A. 101-81, eff. 7-12-19; 102-682, eff. 12-10-21.)

ARTICLE 30.

Section 30-5. The Illinois Income Tax Act is amended by changing Section 223 as follows:

(35 ILCS 5/223)

Sec. 223. Hospital credit.

(a) For tax years ending on or after December 31, 2012 and ending on or before December 31, 2027 ~~December 31, 2022~~, a taxpayer that is the owner of a hospital licensed under the Hospital Licensing Act, but not including an organization that is exempt from federal income taxes under the Internal Revenue Code, is entitled to a credit against the taxes imposed under subsections (a) and (b) of Section 201 of this Act in an amount equal to the lesser of the amount of real property taxes paid during the tax year on real property used for hospital purposes during the prior tax year or the cost of free or discounted services provided during the tax year pursuant to the hospital's charitable financial assistance policy, measured at cost.

(b) If the taxpayer is a partnership or Subchapter S corporation, the credit is allowed to the partners or

shareholders in accordance with the determination of income and distributive share of income under Sections 702 and 704 and Subchapter S of the Internal Revenue Code. A transfer of this credit may be made by the taxpayer earning the credit within one year after the credit is earned in accordance with rules adopted by the Department. The Department shall prescribe rules to enforce and administer provisions of this Section. If the amount of the credit exceeds the tax liability for the year, then the excess credit may be carried forward and applied to the tax liability of the 5 taxable years following the excess credit year. The credit shall be applied to the earliest year for which there is a tax liability. If there are credits from more than one tax year that are available to offset a liability, the earlier credit shall be applied first. In no event shall a credit under this Section reduce the taxpayer's liability to less than zero.

(Source: P.A. 100-587, eff. 6-4-18.)

Section 30-10. 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, 2027 ~~2022~~, tangible personal property sold to or used by a hospital owner that owns one or more hospitals licensed under the Hospital Licensing Act or

1 operated under the University of Illinois Hospital Act, or a
2 hospital affiliate that is not already exempt under another
3 provision of this Act and meets the criteria for an exemption
4 under this Section, is exempt from taxation under this Act.
5 (b) A hospital owner or hospital affiliate satisfies the
6 conditions for an exemption under this Section if the value of
7 qualified services or activities listed in subsection (c) of
8 this Section for the hospital year equals or exceeds the
9 relevant hospital entity's estimated property tax liability,
10 without regard to any property tax exemption granted under
11 Section 15-86 of the Property Tax Code, for the calendar year
12 in which exemption or renewal of exemption is sought. For
13 purposes of making the calculations required by this
14 subsection (b), if the relevant hospital entity is a hospital
15 owner that owns more than one hospital, the value of the
16 services or activities listed in subsection (c) shall be
17 calculated on the basis of only those services and activities
18 relating to the hospital that includes the subject property,
19 and the relevant hospital entity's estimated property tax
20 liability shall be calculated only with respect to the
21 properties comprising that hospital. In the case of a
22 multi-state hospital system or hospital affiliate, the value
23 of the services or activities listed in subsection (c) shall
24 be calculated on the basis of only those services and
25 activities that occur in Illinois and the relevant hospital
26 entity's estimated property tax liability shall be calculated

1 only with respect to its property located in Illinois.
2 (c) The following services and activities shall be
3 considered for purposes of making the calculations required by
4 subsection (b):
5 (1) Charity care. Free or discounted services provided
6 pursuant to the relevant hospital entity's financial
7 assistance policy, measured at cost, including discounts
8 provided under the Hospital Uninsured Patient Discount
9 Act.
10 (2) Health services to low-income and underserved
11 individuals. Other unreimbursed costs of the relevant
12 hospital entity for providing without charge, paying for,
13 or subsidizing goods, activities, or services for the
14 purpose of addressing the health of low-income or
15 underserved individuals. Those activities or services may
16 include, but are not limited to: financial or in-kind
17 support to affiliated or unaffiliated hospitals, hospital
18 affiliates, community clinics, or programs that treat
19 low-income or underserved individuals; paying for or
20 subsidizing health care professionals who care for
21 low-income or underserved individuals; providing or
22 subsidizing outreach or educational services to low-income
23 or underserved individuals for disease management and
24 prevention; free or subsidized goods, supplies, or
25 services needed by low-income or underserved individuals
26 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

1 General Assistance, the Covering ALL KIDS Health Insurance
2 Act, and the State Children's Health Insurance Program.
3 The amount of subsidy for purpose of this item (4) is
4 calculated in the same manner as unreimbursed costs are
5 calculated for Medicaid and other means-tested government
6 programs in the Schedule H of IRS Form 990 in effect on the
7 effective date of this amendatory Act of the 97th General
8 Assembly.
9 (5) Dual-eligible subsidy. The amount of subsidy
10 provided to government by treating dual-eligible
11 Medicare/Medicaid patients. The amount of subsidy for
12 purposes of this item (5) is calculated by multiplying the
13 relevant hospital entity's unreimbursed costs for
14 Medicare, calculated in the same manner as determined in
15 the Schedule H of IRS Form 990 in effect on the effective
16 date of this amendatory Act of the 97th General Assembly,
17 by the relevant hospital entity's ratio of dual-eligible
18 patients to total Medicare patients.
19 (6) Relief of the burden of government related to
20 health care. Except to the extent otherwise taken into
21 account in this subsection, the portion of unreimbursed
22 costs of the relevant hospital entity attributable to
23 providing, paying for, or subsidizing goods, activities,
24 or services that relieve the burden of government related
25 to health care for low-income individuals. Such activities
26 or services shall include, but are not limited to,

1 providing emergency, trauma, burn, neonatal, psychiatric,
2 rehabilitation, or other special services; providing
3 medical education; and conducting medical research or
4 training of health care professionals. The portion of
5 those unreimbursed costs attributable to benefiting
6 low-income individuals shall be determined using the ratio
7 calculated by adding the relevant hospital entity's costs
8 attributable to charity care, Medicaid, other means-tested
9 government programs, Medicare patients with disabilities
10 under age 65, and dual-eligible Medicare/Medicaid patients
11 and dividing that total by the relevant hospital entity's
12 total costs. Such costs for the numerator and denominator
13 shall be determined by multiplying gross charges by the
14 cost to charge ratio taken from the hospital's most
15 recently filed Medicare cost report (CMS 2252-10
16 Worksheet, Part I). In the case of emergency services, the
17 ratio shall be calculated using costs (gross charges
18 multiplied by the cost to charge ratio taken from the
19 hospital's most recently filed Medicare cost report (CMS
20 2252-10 Worksheet, Part I)) of patients treated in the
21 relevant hospital entity's emergency department.
22 (7) Any other activity by the relevant hospital entity
23 that the Department determines relieves the burden of
24 government or addresses the health of low-income or
25 underserved individuals.
26 (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

1 on the property" means the replacement value of any
2 exempt portion of buildings on the property, minus
3 depreciation, determined utilizing the cost
4 replacement method whereby the exempt square footage
5 of all such buildings is multiplied by the replacement
6 cost per square foot for Class A Average building
7 found in the most recent edition of the Marshall &
8 Swift Valuation Services Manual, adjusted by any
9 appropriate current cost and local multipliers.
10 (B) Depreciation, for purposes of calculating the
11 estimated fair market value of buildings on the
12 property, is applied by utilizing a weighted mean life
13 for the buildings based on original construction and
14 assuming a 40-year life for hospital buildings and the
15 applicable life for other types of buildings as
16 specified in the American Hospital Association
17 publication "Estimated Useful Lives of Depreciable
18 Hospital Assets". In the case of hospital buildings,
19 the remaining life is divided by 40 and this ratio is
20 multiplied by the replacement cost of the buildings to
21 obtain an estimated fair market value of buildings. If
22 a hospital building is older than 35 years, a
23 remaining life of 5 years for residual value is
24 assumed; and if a building is less than 8 years old, a
25 remaining life of 32 years is assumed.
26 (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.

1 (2) "Hospital owner" means a not-for-profit
2 corporation that is the titleholder of a hospital, or the
3 owner of the beneficial interest in an Illinois land trust
4 that is the titleholder of a hospital.
5 (3) "Hospital affiliate" means any corporation,
6 partnership, limited partnership, joint venture, limited
7 liability company, association or other organization,
8 other than a hospital owner, that directly or indirectly
9 controls, is controlled by, or is under common control
10 with one or more hospital owners and that supports, is
11 supported by, or acts in furtherance of the exempt health
12 care purposes of at least one of those hospital owners'
13 hospitals.
14 (4) "Hospital system" means a hospital and one or more
15 other hospitals or hospital affiliates related by common
16 control or ownership.
17 (5) "Control" relating to hospital owners, hospital
18 affiliates, or hospital systems means possession, direct
19 or indirect, of the power to direct or cause the direction
20 of the management and policies of the entity, whether
21 through ownership of assets, membership interest, other
22 voting or governance rights, by contract or otherwise.
23 (6) "Hospital applicant" means a hospital owner or
24 hospital affiliate that files an application for an
25 exemption or renewal of exemption under this Section.
26 (7) "Relevant hospital entity" means (A) the hospital

1 owner, in the case of a hospital applicant that is a
2 hospital owner, and (B) at the election of a hospital
3 applicant that is a hospital affiliate, either (i) the
4 hospital affiliate or (ii) the hospital system to which
5 the hospital applicant belongs, including any hospitals or
6 hospital affiliates that are related by common control or
7 ownership.
8 (8) "Subject property" means property used for the
9 calculation under subsection (b) of this Section.
10 (9) "Hospital year" means the fiscal year of the
11 relevant hospital entity, or the fiscal year of one of the
12 hospital owners in the hospital system if the relevant
13 hospital entity is a hospital system with members with
14 different fiscal years, that ends in the year for which
15 the exemption is sought.
16 (i) It is the intent of the General Assembly that any
17 exemptions taken, granted, or renewed under this Section prior
18 to the effective date of this amendatory Act of the 100th
19 General Assembly are hereby validated.
20 (j) It is the intent of the General Assembly that the
21 exemption under this Section applies on a continuous basis. If
22 this amendatory Act of the 102nd General Assembly takes effect
23 after July 1, 2022, any exemptions taken, granted, or renewed
24 under this Section on or after July 1, 2022 and prior to the
25 effective date of this amendatory Act of the 102nd General
26 Assembly are hereby validated.

1 (Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

2 Section 30-15. The Service Use Tax Act is amended by
3 changing Section 3-8 as follows:

4 (35 ILCS 110/3-8)
5 Sec. 3-8. Hospital exemption.
6 (a) Until July 1, 2027 ~~2022~~, tangible personal property
7 sold to or used by a hospital owner that owns one or more
8 hospitals licensed under the Hospital Licensing Act or
9 operated under the University of Illinois Hospital Act, or a
10 hospital affiliate that is not already exempt under another
11 provision of this Act and meets the criteria for an exemption
12 under this Section, is exempt from taxation under this Act.
13 (b) A hospital owner or hospital affiliate satisfies the
14 conditions for an exemption under this Section if the value of
15 qualified services or activities listed in subsection (c) of
16 this Section for the hospital year equals or exceeds the
17 relevant hospital entity's estimated property tax liability,
18 without regard to any property tax exemption granted under
19 Section 15-86 of the Property Tax Code, for the calendar year
20 in which exemption or renewal of exemption is sought. For
21 purposes of making the calculations required by this
22 subsection (b), if the relevant hospital entity is a hospital
23 owner that owns more than one hospital, the value of the
24 services or activities listed in subsection (c) shall be

1 calculated on the basis of only those services and activities
2 relating to the hospital that includes the subject property,
3 and the relevant hospital entity's estimated property tax
4 liability shall be calculated only with respect to the
5 properties comprising that hospital. In the case of a
6 multi-state hospital system or hospital affiliate, the value
7 of the services or activities listed in subsection (c) shall
8 be calculated on the basis of only those services and
9 activities that occur in Illinois and the relevant hospital
10 entity's estimated property tax liability shall be calculated
11 only with respect to its property located in Illinois.

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

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

20 (2) Health services to low-income and underserved
21 individuals. Other unreimbursed costs of the relevant
22 hospital entity for providing without charge, paying for,
23 or subsidizing goods, activities, or services for the
24 purpose of addressing the health of low-income or
25 underserved individuals. Those activities or services may
26 include, but are not limited to: financial or in-kind

1 support to affiliated or unaffiliated hospitals, hospital
2 affiliates, community clinics, or programs that treat
3 low-income or underserved individuals; paying for or
4 subsidizing health care professionals who care for
5 low-income or underserved individuals; providing or
6 subsidizing outreach or educational services to low-income
7 or underserved individuals for disease management and
8 prevention; free or subsidized goods, supplies, or
9 services needed by low-income or underserved individuals
10 because of their medical condition; and prenatal or
11 childbirth outreach to low-income or underserved persons.
12 (3) Subsidy of State or local governments. Direct or
13 indirect financial or in-kind subsidies of State or local
14 governments by the relevant hospital entity that pay for
15 or subsidize activities or programs related to health care
16 for low-income or underserved individuals.
17 (4) Support for State health care programs for
18 low-income individuals. At the election of the hospital
19 applicant for each applicable year, either (A) 10% of
20 payments to the relevant hospital entity and any hospital
21 affiliate designated by the relevant hospital entity
22 (provided that such hospital affiliate's operations
23 provide financial or operational support for or receive
24 financial or operational support from the relevant
25 hospital entity) under Medicaid or other means-tested
26 programs, including, but not limited to, General

1 Assistance, the Covering ALL KIDS Health Insurance Act,
2 and the State Children's Health Insurance Program or (B)
3 the amount of subsidy provided by the relevant hospital
4 entity and any hospital affiliate designated by the
5 relevant hospital entity (provided that such hospital
6 affiliate's operations provide financial or operational
7 support for or receive financial or operational support
8 from the relevant hospital entity) to State or local
9 government in treating Medicaid recipients and recipients
10 of means-tested programs, including but not limited to
11 General Assistance, the Covering ALL KIDS Health Insurance
12 Act, and the State Children's Health Insurance Program.
13 The amount of subsidy for purposes of this item (4) is
14 calculated in the same manner as unreimbursed costs are
15 calculated for Medicaid and other means-tested government
16 programs in the Schedule H of IRS Form 990 in effect on the
17 effective date of this amendatory Act of the 97th General
18 Assembly.

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

1 by the relevant hospital entity's ratio of dual-eligible
2 patients to total Medicare patients.
3 (6) Relief of the burden of government related to
4 health care. Except to the extent otherwise taken into
5 account in this subsection, the portion of unreimbursed
6 costs of the relevant hospital entity attributable to
7 providing, paying for, or subsidizing goods, activities,
8 or services that relieve the burden of government related
9 to health care for low-income individuals. Such activities
10 or services shall include, but are not limited to,
11 providing emergency, trauma, burn, neonatal, psychiatric,
12 rehabilitation, or other special services; providing
13 medical education; and conducting medical research or
14 training of health care professionals. The portion of
15 those unreimbursed costs attributable to benefiting
16 low-income individuals shall be determined using the ratio
17 calculated by adding the relevant hospital entity's costs
18 attributable to charity care, Medicaid, other means-tested
19 government programs, Medicare patients with disabilities
20 under age 65, and dual-eligible Medicare/Medicaid patients
21 and dividing that total by the relevant hospital entity's
22 total costs. Such costs for the numerator and denominator
23 shall be determined by multiplying gross charges by the
24 cost to charge ratio taken from the hospital's most
25 recently filed Medicare cost report (CMS 2252-10
26 Worksheet, Part I). In the case of emergency services, the

1 ratio shall be calculated using costs (gross charges
2 multiplied by the cost to charge ratio taken from the
3 hospital's most recently filed Medicare cost report (CMS
4 2252-10 Worksheet, Part I)) of patients treated in the
5 relevant hospital entity's emergency department.
6 (7) Any other activity by the relevant hospital entity
7 that the Department determines relieves the burden of
8 government or addresses the health of low-income or
9 underserved individuals.
10 (d) The hospital applicant shall include information in
11 its exemption application establishing that it satisfies the
12 requirements of subsection (b). For purposes of making the
13 calculations required by subsection (b), the hospital
14 applicant may for each year elect to use either (1) the value
15 of the services or activities listed in subsection (e) for the
16 hospital year or (2) the average value of those services or
17 activities for the 3 fiscal years ending with the hospital
18 year. If the relevant hospital entity has been in operation
19 for less than 3 completed fiscal years, then the latter
20 calculation, if elected, shall be performed on a pro rata
21 basis.
22 (e) For purposes of making the calculations required by
23 this Section:
24 (1) particular services or activities eligible for
25 consideration under any of the paragraphs (1) through (7)
26 of subsection (c) may not be counted under more than one of

1 those paragraphs; and
2 (2) the amount of unreimbursed costs and the amount of
3 subsidy shall not be reduced by restricted or unrestricted
4 payments received by the relevant hospital entity as
5 contributions deductible under Section 170(a) of the
6 Internal Revenue Code.
7 (f) (Blank).
8 (g) Estimation of Exempt Property Tax Liability. The
9 estimated property tax liability used for the determination in
10 subsection (b) shall be calculated as follows:
11 (1) "Estimated property tax liability" means the
12 estimated dollar amount of property tax that would be
13 owed, with respect to the exempt portion of each of the
14 relevant hospital entity's properties that are already
15 fully or partially exempt, or for which an exemption in
16 whole or in part is currently being sought, and then
17 aggregated as applicable, as if the exempt portion of
18 those properties were subject to tax, calculated with
19 respect to each such property by multiplying:
20 (A) the lesser of (i) the actual assessed value,
21 if any, of the portion of the property for which an
22 exemption is sought or (ii) an estimated assessed
23 value of the exempt portion of such property as
24 determined in item (2) of this subsection (g), by
25 (B) the applicable State equalization rate
26 (yielding the equalized assessed value), by

1 (C) the applicable tax rate.
2 (2) The estimated assessed value of the exempt portion
3 of the property equals the sum of (i) the estimated fair
4 market value of buildings on the property, as determined
5 in accordance with subparagraphs (A) and (B) of this item
6 (2), multiplied by the applicable assessment factor, and
7 (ii) the estimated assessed value of the land portion of
8 the property, as determined in accordance with
9 subparagraph (C).
10 (A) The "estimated fair market value of buildings
11 on the property" means the replacement value of any
12 exempt portion of buildings on the property, minus
13 depreciation, determined utilizing the cost
14 replacement method whereby the exempt square footage
15 of all such buildings is multiplied by the replacement
16 cost per square foot for Class A Average building
17 found in the most recent edition of the Marshall &
18 Swift Valuation Services Manual, adjusted by any
19 appropriate current cost and local multipliers.
20 (B) Depreciation, for purposes of calculating the
21 estimated fair market value of buildings on the
22 property, is applied by utilizing a weighted mean life
23 for the buildings based on original construction and
24 assuming a 40-year life for hospital buildings and the
25 applicable life for other types of buildings as
26 specified in the American Hospital Association

1 publication "Estimated Useful Lives of Depreciable
2 Hospital Assets". In the case of hospital buildings,
3 the remaining life is divided by 40 and this ratio is
4 multiplied by the replacement cost of the buildings to
5 obtain an estimated fair market value of buildings. If
6 a hospital building is older than 35 years, a
7 remaining life of 5 years for residual value is
8 assumed; and if a building is less than 8 years old, a
9 remaining life of 32 years is assumed.
10 (C) The estimated assessed value of the land
11 portion of the property shall be determined by
12 multiplying (i) the per square foot average of the
13 assessed values of three parcels of land (not
14 including farm land, and excluding the assessed value
15 of the improvements thereon) reasonably comparable to
16 the property, by (ii) the number of square feet
17 comprising the exempt portion of the property's land
18 square footage.
19 (3) The assessment factor, State equalization rate,
20 and tax rate (including any special factors such as
21 Enterprise Zones) used in calculating the estimated
22 property tax liability shall be for the most recent year
23 that is publicly available from the applicable chief
24 county assessment officer or officers at least 90 days
25 before the end of the hospital year.
26 (4) The method utilized to calculate estimated

1 property tax liability for purposes of this Section 15-86
2 shall not be utilized for the actual valuation,
3 assessment, or taxation of property pursuant to the
4 Property Tax Code.
5 (h) For the purpose of this Section, the following terms
6 shall have the meanings set forth below:
7 (1) "Hospital" means any institution, place, building,
8 buildings on a campus, or other health care facility
9 located in Illinois that is licensed under the Hospital
10 Licensing Act and has a hospital owner.
11 (2) "Hospital owner" means a not-for-profit
12 corporation that is the titleholder of a hospital, or the
13 owner of the beneficial interest in an Illinois land trust
14 that is the titleholder of a hospital.
15 (3) "Hospital affiliate" means any corporation,
16 partnership, limited partnership, joint venture, limited
17 liability company, association or other organization,
18 other than a hospital owner, that directly or indirectly
19 controls, is controlled by, or is under common control
20 with one or more hospital owners and that supports, is
21 supported by, or acts in furtherance of the exempt health
22 care purposes of at least one of those hospital owners'
23 hospitals.
24 (4) "Hospital system" means a hospital and one or more
25 other hospitals or hospital affiliates related by common
26 control or ownership.

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

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

10 (7) "Relevant hospital entity" means (A) the hospital
11 owner, in the case of a hospital applicant that is a
12 hospital owner, and (B) at the election of a hospital
13 applicant that is a hospital affiliate, either (i) the
14 hospital affiliate or (ii) the hospital system to which
15 the hospital applicant belongs, including any hospitals or
16 hospital affiliates that are related by common control or
17 ownership.

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

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

26 (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.

(j) It is the intent of the General Assembly that the exemption under this Section applies on a continuous basis. If this amendatory Act of the 102nd General Assembly takes effect after July 1, 2022, any exemptions taken, granted, or renewed under this Section on or after July 1, 2022 and prior to the effective date of this amendatory Act of the 102nd General Assembly are hereby validated.

(Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

Section 30-20. 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, 2027 ~~2022~~, 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

1 qualified services or activities listed in subsection (c) of
2 this Section for the hospital year equals or exceeds the
3 relevant hospital entity's estimated property tax liability,
4 without regard to any property tax exemption granted under
5 Section 15-86 of the Property Tax Code, for the calendar year
6 in which exemption or renewal of exemption is sought. For
7 purposes of making the calculations required by this
8 subsection (b), if the relevant hospital entity is a hospital
9 owner that owns more than one hospital, the value of the
10 services or activities listed in subsection (c) shall be
11 calculated on the basis of only those services and activities
12 relating to the hospital that includes the subject property,
13 and the relevant hospital entity's estimated property tax
14 liability shall be calculated only with respect to the
15 properties comprising that hospital. In the case of a
16 multi-state hospital system or hospital affiliate, the value
17 of the services or activities listed in subsection (c) shall
18 be calculated on the basis of only those services and
19 activities that occur in Illinois and the relevant hospital
20 entity's estimated property tax liability shall be calculated
21 only with respect to its property located in Illinois.

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

25 (1) Charity care. Free or discounted services provided
26 pursuant to the relevant hospital entity's financial

1 assistance policy, measured at cost, including discounts
2 provided under the Hospital Uninsured Patient Discount
3 Act.

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

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

1 (4) Support for State health care programs for
2 low-income individuals. At the election of the hospital
3 applicant for each applicable year, either (A) 10% of
4 payments to the relevant hospital entity and any hospital
5 affiliate designated by the relevant hospital entity
6 (provided that such hospital affiliate's operations
7 provide financial or operational support for or receive
8 financial or operational support from the relevant
9 hospital entity) under Medicaid or other means-tested
10 programs, including, but not limited to, General
11 Assistance, the Covering ALL KIDS Health Insurance Act,
12 and the State Children's Health Insurance Program or (B)
13 the amount of subsidy provided by the relevant hospital
14 entity and any hospital affiliate designated by the
15 relevant hospital entity (provided that such hospital
16 affiliate's operations provide financial or operational
17 support for or receive financial or operational support
18 from the relevant hospital entity) to State or local
19 government in treating Medicaid recipients and recipients
20 of means-tested programs, including but not limited to
21 General Assistance, the Covering ALL KIDS Health Insurance
22 Act, and the State Children's Health Insurance Program.
23 The amount of subsidy for purposes of this item (4) is
24 calculated in the same manner as unreimbursed costs are
25 calculated for Medicaid and other means-tested government
26 programs in the Schedule H of IRS Form 990 in effect on the

1 effective date of this amendatory Act of the 97th General
2 Assembly.
3 (5) Dual-eligible subsidy. The amount of subsidy
4 provided to government by treating dual-eligible
5 Medicare/Medicaid patients. The amount of subsidy for
6 purposes of this item (5) is calculated by multiplying the
7 relevant hospital entity's unreimbursed costs for
8 Medicare, calculated in the same manner as determined in
9 the Schedule H of IRS Form 990 in effect on the effective
10 date of this amendatory Act of the 97th General Assembly,
11 by the relevant hospital entity's ratio of dual-eligible
12 patients to total Medicare patients.
13 (6) Relief of the burden of government related to
14 health care. Except to the extent otherwise taken into
15 account in this subsection, the portion of unreimbursed
16 costs of the relevant hospital entity attributable to
17 providing, paying for, or subsidizing goods, activities,
18 or services that relieve the burden of government related
19 to health care for low-income individuals. Such activities
20 or services shall include, but are not limited to,
21 providing emergency, trauma, burn, neonatal, psychiatric,
22 rehabilitation, or other special services; providing
23 medical education; and conducting medical research or
24 training of health care professionals. The portion of
25 those unreimbursed costs attributable to benefiting
26 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

1 activities for the 3 fiscal years ending with the hospital
2 year. If the relevant hospital entity has been in operation
3 for less than 3 completed fiscal years, then the latter
4 calculation, if elected, shall be performed on a pro rata
5 basis.

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

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

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

17 (f) (Blank).

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

21 (1) "Estimated property tax liability" means the
22 estimated dollar amount of property tax that would be
23 owed, with respect to the exempt portion of each of the
24 relevant hospital entity's properties that are already
25 fully or partially exempt, or for which an exemption in
26 whole or in part is currently being sought, and then

1 aggregated as applicable, as if the exempt portion of
2 those properties were subject to tax, calculated with
3 respect to each such property by multiplying:
4 (A) the lesser of (i) the actual assessed value,
5 if any, of the portion of the property for which an
6 exemption is sought or (ii) an estimated assessed
7 value of the exempt portion of such property as
8 determined in item (2) of this subsection (g), by
9 (B) the applicable State equalization rate
10 (yielding the equalized assessed value), by
11 (C) the applicable tax rate.
12 (2) The estimated assessed value of the exempt portion
13 of the property equals the sum of (i) the estimated fair
14 market value of buildings on the property, as determined
15 in accordance with subparagraphs (A) and (B) of this item
16 (2), multiplied by the applicable assessment factor, and
17 (ii) the estimated assessed value of the land portion of
18 the property, as determined in accordance with
19 subparagraph (C).
20 (A) The "estimated fair market value of buildings
21 on the property" means the replacement value of any
22 exempt portion of buildings on the property, minus
23 depreciation, determined utilizing the cost
24 replacement method whereby the exempt square footage
25 of all such buildings is multiplied by the replacement
26 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

1 comprising the exempt portion of the property's land
2 square footage.
3 (3) The assessment factor, State equalization rate,
4 and tax rate (including any special factors such as
5 Enterprise Zones) used in calculating the estimated
6 property tax liability shall be for the most recent year
7 that is publicly available from the applicable chief
8 county assessment officer or officers at least 90 days
9 before the end of the hospital year.
10 (4) The method utilized to calculate estimated
11 property tax liability for purposes of this Section 15-86
12 shall not be utilized for the actual valuation,
13 assessment, or taxation of property pursuant to the
14 Property Tax Code.
15 (h) For the purpose of this Section, the following terms
16 shall have the meanings set forth below:
17 (1) "Hospital" means any institution, place, building,
18 buildings on a campus, or other health care facility
19 located in Illinois that is licensed under the Hospital
20 Licensing Act and has a hospital owner.
21 (2) "Hospital owner" means a not-for-profit
22 corporation that is the titleholder of a hospital, or the
23 owner of the beneficial interest in an Illinois land trust
24 that is the titleholder of a hospital.
25 (3) "Hospital affiliate" means any corporation,
26 partnership, limited partnership, joint venture, limited

1 liability company, association or other organization,
2 other than a hospital owner, that directly or indirectly
3 controls, is controlled by, or is under common control
4 with one or more hospital owners and that supports, is
5 supported by, or acts in furtherance of the exempt health
6 care purposes of at least one of those hospital owners'
7 hospitals.
8 (4) "Hospital system" means a hospital and one or more
9 other hospitals or hospital affiliates related by common
10 control or ownership.
11 (5) "Control" relating to hospital owners, hospital
12 affiliates, or hospital systems means possession, direct
13 or indirect, of the power to direct or cause the direction
14 of the management and policies of the entity, whether
15 through ownership of assets, membership interest, other
16 voting or governance rights, by contract or otherwise.
17 (6) "Hospital applicant" means a hospital owner or
18 hospital affiliate that files an application for an
19 exemption or renewal of exemption under this Section.
20 (7) "Relevant hospital entity" means (A) the hospital
21 owner, in the case of a hospital applicant that is a
22 hospital owner, and (B) at the election of a hospital
23 applicant that is a hospital affiliate, either (i) the
24 hospital affiliate or (ii) the hospital system to which
25 the hospital applicant belongs, including any hospitals or
26 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.

(j) It is the intent of the General Assembly that the exemption under this Section applies on a continuous basis. If this amendatory Act of the 102nd General Assembly takes effect after July 1, 2022, any exemptions taken, granted, or renewed under this Section on or after July 1, 2022 and prior to the effective date of this amendatory Act of the 102nd General Assembly are hereby validated.

(Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

Section 30-25. The Retailers' Occupation Tax Act is amended by changing Section 2-9 as follows:

(35 ILCS 120/2-9)

1 Sec. 2-9. Hospital exemption.
2 (a) Until July 1, 2027 ~~2022~~, tangible personal property
3 sold to or used by a hospital owner that owns one or more
4 hospitals licensed under the Hospital Licensing Act or
5 operated under the University of Illinois Hospital Act, or a
6 hospital affiliate that is not already exempt under another
7 provision of this Act and meets the criteria for an exemption
8 under this Section, is exempt from taxation under this Act.
9 (b) A hospital owner or hospital affiliate satisfies the
10 conditions for an exemption under this Section if the value of
11 qualified services or activities listed in subsection (c) of
12 this Section for the hospital year equals or exceeds the
13 relevant hospital entity's estimated property tax liability,
14 without regard to any property tax exemption granted under
15 Section 15-86 of the Property Tax Code, for the calendar year
16 in which exemption or renewal of exemption is sought. For
17 purposes of making the calculations required by this
18 subsection (b), if the relevant hospital entity is a hospital
19 owner that owns more than one hospital, the value of the
20 services or activities listed in subsection (c) shall be
21 calculated on the basis of only those services and activities
22 relating to the hospital that includes the subject property,
23 and the relevant hospital entity's estimated property tax
24 liability shall be calculated only with respect to the
25 properties comprising that hospital. In the case of a
26 multi-state hospital system or hospital affiliate, the value

1 of the services or activities listed in subsection (c) shall
2 be calculated on the basis of only those services and
3 activities that occur in Illinois and the relevant hospital
4 entity's estimated property tax liability shall be calculated
5 only with respect to its property located in Illinois.

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

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

14 (2) Health services to low-income and underserved
15 individuals. Other unreimbursed costs of the relevant
16 hospital entity for providing without charge, paying for,
17 or subsidizing goods, activities, or services for the
18 purpose of addressing the health of low-income or
19 underserved individuals. Those activities or services may
20 include, but are not limited to: financial or in-kind
21 support to affiliated or unaffiliated hospitals, hospital
22 affiliates, community clinics, or programs that treat
23 low-income or underserved individuals; paying for or
24 subsidizing health care professionals who care for
25 low-income or underserved individuals; providing or
26 subsidizing outreach or educational services to low-income

1 or underserved individuals for disease management and
2 prevention; free or subsidized goods, supplies, or
3 services needed by low-income or underserved individuals
4 because of their medical condition; and prenatal or
5 childbirth outreach to low-income or underserved persons.

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

11 (4) Support for State health care programs for
12 low-income individuals. At the election of the hospital
13 applicant for each applicable year, either (A) 10% of
14 payments to the relevant hospital entity and any hospital
15 affiliate designated by the relevant hospital entity
16 (provided that such hospital affiliate's operations
17 provide financial or operational support for or receive
18 financial or operational support from the relevant
19 hospital entity) under Medicaid or other means-tested
20 programs, including, but not limited to, General
21 Assistance, the Covering ALL KIDS Health Insurance Act,
22 and the State Children's Health Insurance Program or (B)
23 the amount of subsidy provided by the relevant hospital
24 entity and any hospital affiliate designated by the
25 relevant hospital entity (provided that such hospital
26 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

1 that the Department determines relieves the burden of
2 government or addresses the health of low-income or
3 underserved individuals.
4 (d) The hospital applicant shall include information in
5 its exemption application establishing that it satisfies the
6 requirements of subsection (b). For purposes of making the
7 calculations required by subsection (b), the hospital
8 applicant may for each year elect to use either (1) the value
9 of the services or activities listed in subsection (e) for the
10 hospital year or (2) the average value of those services or
11 activities for the 3 fiscal years ending with the hospital
12 year. If the relevant hospital entity has been in operation
13 for less than 3 completed fiscal years, then the latter
14 calculation, if elected, shall be performed on a pro rata
15 basis.
16 (e) For purposes of making the calculations required by
17 this Section:
18 (1) particular services or activities eligible for
19 consideration under any of the paragraphs (1) through (7)
20 of subsection (c) may not be counted under more than one of
21 those paragraphs; and
22 (2) the amount of unreimbursed costs and the amount of
23 subsidy shall not be reduced by restricted or unrestricted
24 payments received by the relevant hospital entity as
25 contributions deductible under Section 170(a) of the
26 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

1 remaining life of 5 years for residual value is
2 assumed; and if a building is less than 8 years old, a
3 remaining life of 32 years is assumed.
4 (C) The estimated assessed value of the land
5 portion of the property shall be determined by
6 multiplying (i) the per square foot average of the
7 assessed values of three parcels of land (not
8 including farm land, and excluding the assessed value
9 of the improvements thereon) reasonably comparable to
10 the property, by (ii) the number of square feet
11 comprising the exempt portion of the property's land
12 square footage.
13 (3) The assessment factor, State equalization rate,
14 and tax rate (including any special factors such as
15 Enterprise Zones) used in calculating the estimated
16 property tax liability shall be for the most recent year
17 that is publicly available from the applicable chief
18 county assessment officer or officers at least 90 days
19 before the end of the hospital year.
20 (4) The method utilized to calculate estimated
21 property tax liability for purposes of this Section 15-86
22 shall not be utilized for the actual valuation,
23 assessment, or taxation of property pursuant to the
24 Property Tax Code.
25 (h) For the purpose of this Section, the following terms
26 shall have the meanings set forth below:

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

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

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

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

21 (5) "Control" relating to hospital owners, hospital
22 affiliates, or hospital systems means possession, direct
23 or indirect, of the power to direct or cause the direction
24 of the management and policies of the entity, whether
25 through ownership of assets, membership interest, other
26 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.

(j) It is the intent of the General Assembly that the exemption under this Section applies on a continuous basis. If this amendatory Act of the 102nd General Assembly takes effect

1 after July 1, 2022, any exemptions taken, granted, or renewed
2 under this Section on or after July 1, 2022 and prior to the
3 effective date of this amendatory Act of the 102nd General
4 Assembly are hereby validated.
5 (Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

6 ARTICLE 999.

7 Section 999-99. Effective date. This Act takes effect upon
8 becoming law.".