HB5301

LRB10418627BABA32070b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5301

Introduced 2/10/2026, by Rep. Suzanne M. Ness

SYNOPSIS AS INTRODUCED:

See Index

Creates the Global Hospital Budget Authority Act. Defines terms. Established the Global Hospital Budget Authority as a Division of the Department of Public Health. Provides that the powers and duties of the Authority shall be vested in and exercised by the Global Hospital Budget Board, which shall have the sole power to employ staff, including an executive director, legal counsel, consultants, or any other staff deemed necessary by the Board to effectuate the purposes of the Act. Provides that individuals employed by the Board shall not be employees of the State for any purpose, including for purposes of compensation, pension benefits, or retirement. Sets forth provisions concerning membership requirements; powers and duties of the Board; roles of participating payers; roles of participant hospitals; data collection and retention; confidentiality of data, contracts, and agreements; and the Global Hospital Budget Fund. Amends the Hospital Licensing Act. Provides that, in reviewing and issuing permits and licenses, the Department shall accept, as factors that satisfy staffing and service-line presence requirements, one or a combination of the following alternative mechanisms if the Department finds that patient safety and continuity of care are maintained: (i) on-site staffing by appropriately licensed clinicians; (ii) written and operative affiliation agreements meeting standards adopted by the Department that provide timely specialty coverage; (iii) documented telemedicine coverage that meets certain standards; or (iv) a waiver issued under certain provisions for a rural or critical access hospital. In provisions concerning requirements for the employment of physicians, provides that employing entities may employ physicians to practice medicine in all of its branches if employment, privileging, and oversight requirements are met. Amends the Illinois Health Facilities Planning Act. Makes changes in provisions concerning definitions; certificates of exemption for change of ownership of a health care facility; applications for permit for discontinuation of a health care facility or category of service; and the powers and duties of State Board. Amends the State Finance Act to make a conforming change.

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A BILL FOR

AN ACT concerning regulation.

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

Section 1. Short title. This Act may be cited as the Global Hospital Budget Authority Act.

Section 2. Purpose. The purpose of this Act is to protect and promote access of the residents of this State to high-quality health care in all communities by encouraging innovation in health care delivery.

Section 5. Definitions. In this Act:

"Authority" means the Global Hospital Budget Authority within the Department of Public Health.

"Board" means the Global Hospital Budget Board.

"Conflict of interest" means situation in which a Board member:

(1) has an interest in one or more parties involved in an action under Section 303 of the Illinois Income Tax Act; and

(2) may gain access to competitively sensitive or strategically relevant information about a participating payer or participant hospital.

"Department" means the Department of Public Health.

"Director" means the Director of Public Health.

"Eligible hospital" means any general acute care hospital, critical access hospital, specialty hospital, or children's hospital licensed under the Hospital Licensing Act that provides inpatient services in this State, excluding:

(1) Psychiatric hospitals;

(2) Long-term acute care hospitals;

(3) Rehabilitation hospitals; and

(4) Federal hospitals operated by the United States Department of Veterans Affairs or Department of Defense.

"Eligible hospital services" means all inpatient and hospital- based outpatient items and services. "Eligible hospital services" excludes all other items and services, including the following:

(1) Post-acute care.

(2) Professional services.

(3) Durable medical equipment.

(4) Dental services.

(5) Non-inpatient or non-hospital-based outpatient behavioral health services.

(6) Long-term care services, except for swing bed services for critical access hospitals.

"Fund" means the Global Hospital Budget Fund.

"Global budget" means the prospectively set annual budget that is the basis of payment of each participant hospital for eligible hospital services by participating payers.

"Global budget model" means an innovative payment and service delivery model that is intended to reduce health care costs while maintaining access to care, improving the quality of care across all counties, and meeting the health needs of participant hospitals' local communities, and under which participating payers pay participant hospitals using a global budget methodology established by the Authority.

"Government program" means a health benefit plan offered or administered by or on behalf of the United States, this State, or an agency or instrumentality of either, including:

(1) The medical assistance program established under Article V of the Illinois Public Aid Code.

(2) The Children's Health Insurance Program established under the Children's Health Insurance Program Act.

(3) A health benefit plan offered or administered by or on behalf of the State or an agency or instrumentality of the State.

(4) Health care benefits administered under Title 10 or Title 38 of the United States Code.

(5) The Medicare program established under Title XVIII of the Social Security Act.

"Hospital" means a hospital licensed under the Hospital Licensing Act.

"Hospital budget transformation plan" means a description of the health care delivery system transformation that a

participant hospital undergoes under the global budget model, as approved by the Board and the federal government.

"Insurer" means a person, corporation, or other entity licensed by the State with Authority to offer, issue, or renew an insurance policy, subscriber contract, or certificate providing health care coverage, including:

(1) An insurance company, association, or exchange governed by the Illinois Insurance Code.

(2) A health services plan corporation.

(3) A professional service corporation that renders professional services in health care.

(4) A health maintenance organization governed by the Health Maintenance Organization Act.

"Medicaid managed care organization" means entity, as defined in 42 U.S.C. 1396b(m)(1)(A), that is a party to an agreement with the Department of Human Services. "Medicaid managed care organization" includes a county Medicaid managed care organization and a permitted assignee of an agreement. "Medicaid managed care organization" does not include an assignor of an agreement.

"Participant hospital" means a hospital that signs an agreement to participate in the global budget model.

"Participating payer" means a payer that operates in this State and, with respect to one or more specified products, programs, or payment arrangements, signs an agreement with the Authority to participate in the global budget model.

"Payer" means an insurer, government program, or Medicaid managed care organization that pays or administers payment for health care services under an insurance policy, subscriber contract, certificate, administrative services arrangement, or other payment arrangement.

Section 10. Global Hospital Budget Authority.

(a) The Global Hospital Budget Authority is established as a Division of the Department of Public Health. The powers and duties of the Authority shall be vested in and exercised by the Global Hospital Budget Board, which shall have the sole power to employ staff, including an executive director, legal counsel, consultants, or any other staff deemed necessary by the Board to effectuate the purposes of this Act. Individuals employed by the Board shall not be employees of the State for any purpose, including for purposes of compensation, pension benefits, or retirement.

(b) The Board shall consist of the following members:

(1) The Director or the Director's designee, who shall be an employee of the Department designated in writing prior to service.

(2) The Secretary of Human Services or the Secretary's designee, who shall be an employee of the Department of Human Services designated in writing prior to service.

(3) The Director of Insurance or the Director's designee, who shall be an employee of the Department of

Insurance designated in writing prior to service.

(4) One member selected by each participating payer that is an insurer on behalf of the participating payer and the participating payer's parents, affiliates, subsidiaries, other associated entities, and successors, excluding any affiliated, subsidiary, or otherwise associated Medicaid managed care organization.

(5) One member selected by each participating payer that is a Medicaid managed care organization.

(6) One member selected by an organization representing hospitals and health systems in this State. This member shall be considered a participant hospital member on the Board.

(7) Participant hospital members, the number of which shall not exceed the number of participating payer members. The participant hospital members shall represent the participant hospitals, shall be selected from different, geographically diverse participant hospitals, and shall be appointed as follows:

(A) The President Pro Tempore of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives and the Minority Leader of the House of Representatives shall each appoint one member.

(B) The Governor shall appoint the remaining members.

(8) One member appointed by the Governor that is a statewide organization advocating on behalf of consumers for consumer rights in a health care setting.

(9) Two members appointed by the Governor who are nationally recognized experts in health care delivery or in developing and administering global budgets.

(c) The terms of the members of the Board shall be as follows:

(1) The terms of the members specified under paragraphs (1), (2) and (3) of subsection (b) shall be concurrent with their holding of public office.

(2) The Board members specified in paragraphs (4), (5), (6), (7) and (8) of subsection (b) shall serve for a term of 4 years and shall not be eligible to serve more than 2 full consecutive 4-year terms. If a member leaves the Board prior to completing a 4-year term due to a change in professional status, including, but not limited to, retirement, changing jobs, failure to qualify, or similar reasons, a new member shall be appointed or selected within 60 days after the seat becomes vacant.

(d) The Governor shall appoint a chairperson from among the Board members.

(e) A majority of the members of the Board shall constitute a quorum. Action may be taken by the Board at a meeting upon a vote of a majority of its members present in person or through electronic means. If a tie vote occurs at any

meeting, it shall be the duty of the chairperson to cast the deciding vote.

(f) The Board shall meet at the call of the chairperson or as may be provided in the bylaws of the Board. The Board shall hold meetings at least quarterly, which shall be subject to the requirements of the Open Meetings Act.

(g) The Board shall be formed within 90 days after the effective date of this Act.

(h) Board members shall recuse themselves from discussions and actions where a conflict of interest may exist. Board members may not receive confidential information, data, or material related to an entity where a conflict of interest may exist.

(i) Members of the Board shall not receive a salary or per diem allowance for serving as members of the Board but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. Reasonable expenses may include the reimbursement of travel and living expenses while engaged in Board business. The reimbursements shall be paid for by the Fund.

Section 15. Powers and duties.

(a) The Board shall exercise all powers necessary and appropriate to carry out its duties under this Act, including the following:

(1) Adopt bylaws necessary to carry out the provisions

of this Act. The bylaws shall include a provision addressing conflicts of interest as well as a provision that restricts Board discussions and decisions to the administration of the global budget model as provided under subsection (b).

(2) Make, execute, and deliver contracts, grants, and other instruments necessary or convenient to exercise the powers and duties of the Board.

(3) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract or grant for, administer, and expend money in the Fund and other money made available to the Authority from any other source consistent with the purposes of this act. The Authority shall be exempt from the applicable provisions of the Illinois Procurement Code.

(4) Apply for, accept, and administer grants and loans to carry out the purposes of the Authority.

(5) Accept money from both public and private sources, consistent with federal and State law.

(6) Take, hold, administer, assign, lend, encumber, mortgage, invest, or otherwise dispose of, at a public or private sale, on behalf of the Authority and for any of the Authority's purposes, real property, personal property, and money or any interest therein, including any mortgage or loan interest owned by the Authority, under the Authority's control, or in the Authority's possession and

the income from the real or personal property either absolutely or in trust and including the following abilities:

(A) The Board may acquire property or money for this purpose by purchase or lease and by the acceptance of gifts, grants, bequests, devises, or loans, but no obligation of the Authority shall be a debt of the State, and the Authority shall have no power to pledge the credit or taxing power of the State nor to make its debts payable out of any money except that of the Authority. This subparagraph (A) shall not be construed as allowing the Board to acquire hospitals or participant hospitals.

(B) All accrued and future earnings from money invested by the Board and other accrued and future nonappropriated funds, including, but not limited to, funds obtained from the federal Government and any contributions, shall be available to the Authority, shall be deposited in the State Treasury, and may be utilized at the discretion of the Board for carrying out any of the corporate purposes of the Authority. Any placement of the funds by the State Treasurer in depositories or investments shall be consistent with guidelines approved by the Board.

(7) Seek waivers from State agency requirements as necessary to carry out the purposes of this Act.

(8) Coordinate with the appropriate State agency to seek waivers from federal requirements as necessary to carry out the purposes of this Act.

(9) Establish advisory groups with diverse memberships representing interested and affected groups and individuals as the Board finds necessary to carry out the purposes of this Act.

(10) Collaborate with all applicable State agencies for purposes of implementing this Act.

(11) Perform all other activities necessary to further the purposes of this Act.

(b) The Board shall be responsible for administering the global budget model and shall:

(1) Evaluate and select hospitals for participation in the global budget model as participant hospitals on the basis of diversity, vision, and commitment to health care delivery transformation.

(2) Provide technical assistance, training, and education to participant hospitals.

(3) Collect and maintain data from participant hospitals, participating payers, and others as necessary to carry out the responsibilities of this Act.

(4) Perform data analysis and quality assurance.

(5) Calculate, approve, and administer global budgets. The global budgets may include payments for eligible hospital services provided under a participant hospital's

employee health plan.

(6) Consistent with federal and State law, review and approve hospital transformation plans, advise and approve changes to operational and payment mechanisms, and approve exceptions to agreed-upon payment rules through an approved procedure provided in the Board's bylaws. For the purpose of administration, the Authority shall be subject to the relevant provisions of the Illinois Administrative Code.

(7) Assist hospitals and participant hospitals in working with community-based organizations to determine targeted population health improvement goals.

(8) Evaluate the progress of the implementation of each participant hospital's global budget toward population health improvement goals and the cost of achieving those goals.

(9) Monitor global budgets and quality metrics for participant hospitals.

(10) Provide an annual assessment of each rural participant hospital's compliance with its hospital transformation plan and global budget targets.

(11) Require a participant hospital to submit a corrective action plan for failure to submit a hospital transformation plan, to comply with its hospital transformation plan, or to meet its global budget targets.

(12) Terminate a participant hospital from the global

budget model in accordance with the rural participant hospital's participation agreement.

(13) Contract with an independent evaluation group to provide the Board and Director with an evaluation of the global budget model's progress in the areas of population health, quality of care, and cost targets.

(14) Review and update its definition of "eligible hospital services", subject to obtaining all necessary federal approvals. The Board shall use data collected under paragraph (3) in its review.

(c)(1) The accounts and books of the Authority shall be examined and audited annually by an independent certified public accounting firm. The audit shall be public information.

(2) The Authority shall, by December 31 of each year, file a copy of the audit of the preceding State fiscal year required under paragraph (1) with the Secretary of the Senate and the Chief Clerk of the House of Representatives and provide a copy to the Department.

(d) The Authority shall:

(1) Electronically submit an annual report on the performance and compliance of each participant rural hospital to the Department and to other appropriate parties, including associations, foundations, academic institutions, and community-based organizations, as determined by the Board.

(2) Electronically submit an annual report to the

Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives for distribution to the Health and Human Services Committee of the Senate and the Health Care Availability and Access Committee of the House of Representatives on the activities of the Authority for the year.

(3) Comply with applicable federal reporting requirements.

(e) The Authority shall annually transmit a financial statement and the Authority's audit as a notice for publication in the Illinois Register.

Section 20. Roles of participating payers.

(a) A payer may submit a letter of interest to the Authority to participate in the global budget model.

(b) As a condition of participation, a participating payer shall sign an agreement with the Authority. The agreement shall detail the terms and conditions of participation in the global budget model.

(c) A participating payer may terminate its participation with a participant hospital according to the terms and conditions of the agreement under subsection (b).

Section 25. Roles of participant hospitals.

(a) A hospital may submit a letter of interest to the Authority to participate in the global budget model.

(b) As a condition of participation, the following shall occur:

(1) A hospital shall submit an initial rural hospital budget transformation plan in the manner and form prescribed by the Authority for review and approval.

(2) A participant hospital shall sign an agreement with the Authority. The agreement shall detail the terms and conditions of participation in the global budget model.

(3) A participant hospital shall submit annual updates to its rural hospital budget transformation plan in the manner and form prescribed by the Authority for review and approval.

Section 30. Data collection and retention.

(a) The Authority may collect and analyze any data from participating payers, rural hospitals, rural participant hospitals, and the Department of Human Services necessary to carry out the Authority's responsibilities under this Act. Data collected by the Authority shall only be used for administering the global budget model. The Authority shall obtain the written approval of a participating payer, rural hospital, rural participant hospital, or the Department of Human Services before the Authority can use the entity's data for any other purpose. The Authority shall retain the data for no more than 7 years.

(b) A rural participant hospital may authorize its insurer or administrator to provide data to the Authority regarding payments for eligible hospital services provided under the hospital's employee health plan.

(c) Unless specifically provided for in this Act, the Authority may not release and no data source, person, member of the public, or other user of any data of the Authority may gain access to:

(1) Raw data which could reasonably be expected to reveal the identity of an individual patient.

(2) Raw data disclosing discounts or allowances between participating payers and participant rural hospitals that is prejudicial to an individual participating payer or participant rural hospital.

(3) Data which the Department of Human Services provides to the Authority, unless the Secretary of Human Services or Secretary's designee specifically authorizes the release or access.

(4) Any data where a conflict of interest occurs.

Section 35. Confidentiality of data, contracts, and agreements.

(a) Any contract or agreement between participating payers and rural participant hospitals or any data, including patient data, provided by a participating payer, a rural participant hospital, including a rural participant hospital's insurer or

administrator, a rural hospital, or the Department of Human Services to the Authority and maintained by the Authority for the purposes of carrying out the requirements of this Act shall be confidential and shall not be discoverable or admissible as evidence in any civil, criminal, or administrative action or proceeding.

(b) Nothing in this Section shall prohibit the Authority from accessing the data to carry out its responsibilities in accordance with law.

(c) Data provided to the Centers for Medicare and Medicaid Services, or any other entity, by the Authority shall be provided consistent with applicable laws and regulations, including the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and any implementing regulations, to the extent allowed by law and written agreements between the Authority and each participating payer and rural participant hospital.

Section 40. The Global Hospital Budget Fund.

(a) The Global Hospital Budget Fund is created as a separate fund in the State Treasury.

(b) All moneys deposited into the Fund shall be held for the purposes of the Authority and shall be used only to effectuate the purposes of this Act as determined by the Authority. All interest earned from the investment or deposit

of moneys accumulated in the Fund shall be deposited in the Fund for the same use. Any moneys returned to the Authority by any party shall be deposited into the Fund.

Section 41. The State Finance Act is amended by adding Section 5.1038 as follows:

(30 ILCS 105/5.1038 new)

Sec. 5.1038. The Global Hospital Budget Fund.

Section 45. The Hospital Licensing Act is amended by changing Sections 4, 10.8, and by adding Section 18 as follows:

(210 ILCS 85/4) (from Ch. 111 1/2, par. 145)

Sec. 4. No person shall establish a hospital without first obtaining a permit from the Department and no person shall open, conduct, operate, or maintain a hospital without first obtaining a license from the Department.

Nothing in this Act shall be construed to impair or abridge the power of municipalities to license and regulate hospitals, provided that the municipal ordinance substantially complies with the minimum standards and regulations developed by the Department pursuant to the provisions of this Act. Such compliance shall be determined by the Department subject to review as provided in Section 13 of this Act. Section 13 of

this Act shall also be applicable to the judicial review of final administrative decisions of the regulatory agency of the municipality. Any municipality having an ordinance licensing and regulating hospitals which provides for minimum standards and regulations substantially in compliance with those developed pursuant to this Act shall make such periodic reports to the Department as the Department deems necessary. This report shall include a list of hospitals meeting standards substantially equivalent to those promulgated by the Department under this Act, and upon the receipt of such report the Department may then issue a license to such hospital.

In reviewing and issuing permits and licenses, the Department shall accept, as factors that satisfy staffing and service-line presence requirements, one or a combination of the following alternative mechanisms if the Department finds that patient safety and continuity of care are maintained: (i) on-site staffing by appropriately licensed clinicians; (ii) written and operative affiliation agreements meeting standards adopted by the Department that provide timely specialty coverage; (iii) documented telemedicine coverage that meets standards in Section 6.21; or (iv) a waiver issued under Section 6.21 for a rural or critical access hospital. The Department shall not impose an on-site specialty presence requirement for any service if the hospital demonstrates through documentation that an alternative mechanism described in items (i) through (iv) will provide clinically equivalent,

timely care and safe transfer protocols.

Waiver approvals shall be time-limited, not to exceed 24 months, and may be renewed upon demonstration of continued need and compliance with quality and transfer metrics. The Department shall provide technical assistance, model affiliation, and telemedicine contract templates to applicants.

(Source: Laws 1965, p. 2350.)

(210 ILCS 85/10.8)

Sec. 10.8. Requirements for employment of physicians.

(a) Physician employment by hospitals and hospital affiliates. Employing entities may employ physicians to practice medicine in all of its branches provided that the following requirements are met:

(1) The employed physician is a member of the medical staff of either the hospital or hospital affiliate. If a hospital affiliate decides to have a medical staff, its medical staff shall be organized in accordance with written bylaws where the affiliate medical staff is responsible for making recommendations to the governing body of the affiliate regarding all quality assurance activities and safeguarding professional autonomy. The affiliate medical staff bylaws may not be unilaterally changed by the governing body of the affiliate. Nothing in this Section requires hospital affiliates to have a

medical staff.

(2) Independent physicians, who are not employed by an employing entity, periodically review the quality of the medical services provided by the employed physician to continuously improve patient care.

(3) The employing entity and the employed physician sign a statement acknowledging that the employer shall not unreasonably exercise control, direct, or interfere with the employed physician's exercise and execution of his or her professional judgment in a manner that adversely affects the employed physician's ability to provide quality care to patients. This signed statement shall take the form of a provision in the physician's employment contract or a separate signed document from the employing entity to the employed physician. This statement shall state: "As the employer of a physician, (employer's name) shall not unreasonably exercise control, direct, or interfere with the employed physician's exercise and execution of his or her professional judgment in a manner that adversely affects the employed physician's ability to provide quality care to patients."

(4) The employing entity shall establish a mutually agreed upon independent review process with criteria under which an employed physician may seek review of the alleged violation of this Section by physicians who are not employed by the employing entity. The affiliate may

arrange with the hospital medical staff to conduct these reviews. The independent physicians shall make findings and recommendations to the employing entity and the employed physician within 30 days of the conclusion of the gathering of the relevant information.

(a-5) Employing entities may employ physicians to practice medicine in all of its branches if employment, privileging, and oversight requirements are met. For purposes of determining compliance with any requirement that requires a hospital to maintain a clinical service or specialty, the presence of a specialty may be satisfied in whole or in part through documented telemedicine arrangements, affiliation agreements, shared staffing models, or approved waivers under Section 6.21, as long as the hospital maintains written transfer agreements, response-time expectations, clinician credentialing consistent with the applicable standard of care, and measures that assure continuous quality of care.

(b) Definitions. For the purpose of this Section:

"Employing entity" means a hospital licensed under the Hospital Licensing Act or a hospital affiliate.

"Employed physician" means a physician who receives an IRS W-2 form, or any successor federal income tax form, from an employing entity.

"Hospital" means a hospital licensed under the Hospital Licensing Act, except county hospitals as defined in subsection (c) of Section 15-1 of the Illinois Public Aid

Code.

"Hospital affiliate" means a corporation, partnership, joint venture, limited liability company, or similar organization, other than a hospital, that is devoted primarily to the provision, management, or support of health care services and that directly or indirectly controls, is controlled by, or is under common control of the hospital. "Control" means having at least an equal or a majority ownership or membership interest. A hospital affiliate shall be 100% owned or controlled by any combination of hospitals, their parent corporations, or physicians licensed to practice medicine in all its branches in Illinois. "Hospital affiliate" does not include a health maintenance organization regulated under the Health Maintenance Organization Act.

"Physician" means an individual licensed to practice medicine in all its branches in Illinois.

"Professional judgment" means the exercise of a physician's independent clinical judgment in providing medically appropriate diagnoses, care, and treatment to a particular patient at a particular time. Situations in which an employing entity does not interfere with an employed physician's professional judgment include, without limitation, the following:

(1) practice restrictions based upon peer review of the physician's clinical practice to assess quality of care and utilization of resources in accordance with

applicable bylaws;

(2) supervision of physicians by appropriately licensed medical directors, medical school faculty, department chairpersons or directors, or supervising physicians;

(3) written statements of ethical or religious directives; and

(4) reasonable referral restrictions that do not, in the reasonable professional judgment of the physician, adversely affect the health or welfare of the patient.

(c) Private enforcement. An employed physician aggrieved by a violation of this Act may seek to obtain an injunction or reinstatement of employment with the employing entity as the court may deem appropriate. Nothing in this Section limits or abrogates any common law cause of action. Nothing in this Section shall be deemed to alter the law of negligence.

(d) Department enforcement. The Department may enforce the provisions of this Section, but nothing in this Section shall require or permit the Department to license, certify, or otherwise investigate the activities of a hospital affiliate not otherwise required to be licensed by the Department.

(e) Retaliation prohibited. No employing entity shall retaliate against any employed physician for requesting a hearing or review under this Section. No action may be taken that affects the ability of a physician to practice during this review, except in circumstances where the medical staff

bylaws authorize summary suspension.

(f) Physician collaboration. No employing entity shall adopt or enforce, either formally or informally, any policy, rule, regulation, or practice inconsistent with the provision of adequate collaboration, including medical direction of licensed advanced practice registered nurses or supervision of licensed physician assistants and delegation to other personnel under Section 54.5 of the Medical Practice Act of 1987.

(g) Physician disciplinary actions. Nothing in this Section shall be construed to limit or prohibit the governing body of an employing entity or its medical staff, if any, from taking disciplinary actions against a physician as permitted by law.

(h) Physician review. Nothing in this Section shall be construed to prohibit a hospital or hospital affiliate from making a determination not to pay for a particular health care service or to prohibit a medical group, independent practice association, hospital medical staff, or hospital governing body from enforcing reasonable peer review or utilization review protocols or determining whether the employed physician complied with those protocols.

(i) Review. Nothing in this Section may be used or construed to establish that any activity of a hospital or hospital affiliate is subject to review under the Illinois Health Facilities Planning Act.

(j) Rules. The Department shall adopt any rules necessary to implement this Section.

(Source: P.A. 100-201, eff. 8-18-17; 100-513, eff. 1-1-18.)

(210 ILCS 85/18 new)

Sec. 18. Affiliation agreements and telemedicine service protocols. The Department shall, within 6 months after the effective date of this amendatory Act of the 104th General Assembly, adopt rules implementing Sections 3.1 and 6.21 and shall make publicly available guidance templates for affiliation agreements and telemedicine service protocols. The Department shall report to the General Assembly within 18 months after the effective date of this amendatory Act of the 104th General Assembly on the number of waivers issued, the outcomes, and any impacts on access to care.

Section 50. The Illinois Health Facilities Planning Act is amended by changing Sections 3, 8.5, 8.7, and 12 as follows:

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

(Section scheduled to be repealed on December 31, 2029)

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

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

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

Treatment Center Act.

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

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

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

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

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

Board as provided in Section 14.1 of this Act.

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

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

(5) Kidney disease treatment centers, including a free-standing hemodialysis unit required to meet the requirements of 42 CFR 494 in order to be certified for participation in Medicare and Medicaid under Titles XVIII and XIX of the federal Social Security Act.

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

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

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

proposed kidney disease treatment centers.

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

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

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

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

(1) Federally-owned facilities.

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

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

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

Housing Act.

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

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

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

(8) Any change of ownership of a health care facility that is licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the

ID/DD Community Care Act, or the MC/DD Act, with the exception of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care Act.

(9) (Blank).

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups, unless the entity constructs, modifies, or establishes a health care facility as specifically defined in this Section. This Act shall apply to construction or modification and to establishment by such health care facility

of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

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

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

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

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility

which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion project undertaken in accordance with Section 30 of the Older Adult Services Act shall be excluded from any obligations under this Act.

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

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

"Capital expenditure" means an expenditure: (A) made by or

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

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

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

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

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; components in a patient care unit used as educational space, consultation and touchdown rooms, and on-call rooms; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components

(such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. "Non-clinical service area" does not include health and fitness centers, areas in a patient care unit, or areas that are required by Department licensing standards, including life safety code regulations, such as hallways and other interdependent components to a clinical area.

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

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

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

"Licensed health care professional" means a person licensed to practice a health profession under pertinent

licensing statutes of the State of Illinois.

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

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

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

"Acquiring interest" means any acquisition, directly or indirectly, of a controlling ownership interest in a health care facility or health system, including by merger, stock purchase, asset purchase, management contract, lease of substantially all operations, or change in controlling membership or partnership interests.

"Out-of-state facility" means a person that is both (i) licensed as a hospital or as an ambulatory surgery center under the laws of another state or that qualifies as a hospital or an ambulatory surgery center under regulations adopted pursuant to the Social Security Act and (ii) not licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act. Affiliates of out-of-state facilities shall be considered out-of-state facilities. Affiliates of Illinois licensed health care facilities 100% owned by an Illinois licensed health care facility, its parent, or Illinois physicians licensed to practice medicine in all its branches shall not be

considered out-of-state facilities. Nothing in this definition shall be construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

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

"Control" means the power to direct or cause the direction of management and policies of a facility or system, whether by ownership of voting securities, by contract, or otherwise.

"Covered transaction" means any proposed acquiring interest or transfer of ownership of a hospital, or any proposed material change in ownership, management, or governance that results in the transfer of control.

"Material service reduction" includes, but is not limited to: (i) closure or suspension of inpatient beds, (ii) emergency department closure or downsizing, (iii) elimination of maternity or labor-and-delivery services, (iv) elimination of behavioral health services, (v) elimination of essential surgical or diagnostic capabilities, (vi) major staffing reductions likely to affect patient access, or (vii) termination of community health programs.

"Private equity" means an entity that is principally engaged in acquiring equity interests in operating businesses for investment purposes, including buyout funds, venture capital funds, hedge funds, or other pooled investment vehicles, and any affiliated or successor entities through which such funds hold their interests.

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

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

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

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice of a physician or other licensed health care professional

while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

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

"Patient care unit" means a physically identifiable and organized unit in a clearly defined administrative and geographic area that meets applicable standards of service in which nursing care and therapeutic services are provided on a continuous basis and to which specific nursing and support staff are assigned. "Patient care unit" does not include education spaces, consultation and touchdown rooms, and on-call rooms that are not required by Department licensing standards.

"Provider" includes, but is not limited to, a hospital, long-term care facility, end-stage renal dialysis facility, ambulatory surgical treatment center, freestanding emergency center, or birth center.

(Source: P.A. 104-365, eff. 1-1-26.)

(20 ILCS 3960/8.5)

(Section scheduled to be repealed on December 31, 2029)

Sec. 8.5. Certificate of exemption for change of ownership

of a health care facility; discontinuation of a category of service; public notice and public hearing.

(a) Upon a finding that an application for a change of ownership is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The applicant shall pay the cost incurred by the Board in publishing the change of ownership notice in newspapers as required under this subsection. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located and to the Office of the Attorney General. An application for change of ownership of a hospital shall not be deemed complete without a signed certification that for a period of 2 years after the change of ownership transaction is effective, the hospital will not adopt a charity care policy that is more restrictive than the policy in effect during the year prior to the transaction. An application for a change of

ownership need not contain signed transaction documents so long as it includes the following key terms of the transaction: names and background of the parties; structure of the transaction; the person who will be the licensed or certified entity after the transaction; the ownership or membership interests in such licensed or certified entity both prior to and after the transaction; fair market value of assets to be transferred; and the purchase price or other form of consideration to be provided for those assets. The issuance of the certificate of exemption shall be contingent upon the applicant submitting a statement to the Board within 90 days after the closing date of the transaction, or such longer period as provided by the Board, certifying that the change of ownership has been completed in accordance with the key terms contained in the application. If such key terms of the transaction change, a new application shall be required.

Where a change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under this Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership. Once such an application is submitted to the Board and reviewed by the Board staff, the Board Chair shall take action on an application for an exemption for a change of ownership among related persons within 45 days after the

application has been deemed complete, provided the application meets the applicable standards under this Section. If the Board Chair has a conflict of interest or for other good cause, the Chair may request review by the Board. Notwithstanding any other provision of this Act, for purposes of this Section, a change of ownership among related persons means a transaction where the parties to the transaction are under common control or ownership before and after the transaction is completed.

Nothing in this Act shall be construed as authorizing the Board to impose any conditions, obligations, or limitations, other than those required by this Section, with respect to the issuance of an exemption for a change of ownership, including, but not limited to, the time period before which a subsequent change of ownership of the health care facility could be sought, or the commitment to continue to offer for a specified time period any services currently offered by the health care facility.

The changes made by this amendatory Act of the 103rd General Assembly are inoperative on and after January 1, 2027.

In addition to other materials required by this Section, any application for a change of ownership that constitutes a covered transaction shall include:

(1) a complete ownership chain disclosing the ultimate beneficial owners and identifying any private equity or pooled-investment entities in the chain;

(2) the transaction agreement and all material

ancillary agreements, including, but not limited to, management agreements, leases of substantially all operations, sale-leasebacks, service contracts, and contingent liability instruments;

(3) audited and pro forma financial statements for the facility and the acquiring entity for at least 5 years following the proposed transaction that is prepared consistent with generally accepted accounting principles, and a statement of sources and uses of funds for the transaction;

(4) a written statement disclosing any intended or anticipated material service reductions within 3 years of closing and a mitigation plan;

(5) a Community Health Impact Assessment (CHIA), prepared by an independent qualified third party that meets Board standards, analyzing baseline access and projected impacts on service availability, capacity, staffing, payer mix, and at least 2 relevant community health outcome measures; and

(6) a proposed post-transaction monitoring plan, proposed community benefit commitments, and employee transition protections.

The Board shall not approve any covered transaction until completion of the Board's review, which shall include evaluation of the CHIA and any public comments or interventions. The Board may extend review timelines as

necessary to complete independent evaluations.

For any covered transaction involving private equity or a non-operating financial investor, the acquiring party shall bear the burden of proof by a preponderance of the evidence to demonstrate that the transaction will not materially impair access to essential services, quality of care, or community health outcomes in the facility's service area.

The Board may approve, approve with conditions, or deny a covered transaction. When approving, the Board may impose conditions, including, but not limited to: (i) minimum service-level guarantees and minimum staffing levels for a specified period of no less than 3 years, (ii) capital investment commitments, (iii) restrictions on dividend distributions or leveraged recapitalizations for a specified period, (iv) binding community benefit agreements, and (v) requirements to maintain charity care levels at prior or higher levels. The Board shall monitor compliance with all conditions for a minimum of 5 years post-transaction and may assess penalties, require restoration of services, or order divestiture for material noncompliance.

The Board shall require full disclosure of beneficial ownership and fee structures associated with the acquiring entity. Only disclosing shell companies or nominee entities shall not constitute full disclosure. Financial documents may be submitted under protective order, but confidentiality claims do not relieve the applicant of the burden of proof.

(a-3) (Blank).

(a-5) Upon a finding that an application to discontinue a category of service is complete and provides the requested information, as specified by the State Board, an exemption shall be issued. No later than 30 days after the issuance of the exemption, the health care facility must give written notice of the discontinuation of the category of service to the State Senator and State Representative serving the legislative district in which the health care facility is located. No later than 90 days after a discontinuation of a category of service, the applicant must submit a statement to the State Board certifying that the discontinuation is complete.

(b) If a public hearing is requested, it shall be held at least 15 days but no more than 30 days after the date of publication of the legal notice in the community in which the facility is located. The hearing shall be held in the affected area or community in a place of reasonable size and accessibility and a full and complete written transcript of the proceedings shall be made. All interested persons attending the hearing shall be given a reasonable opportunity to present their positions in writing or orally. The applicant shall provide a summary or describe the proposed change of ownership at the public hearing.

(c) For the purposes of this Section "newspaper of limited circulation" means a newspaper intended to serve a particular

or defined population of a specific geographic area within a Metropolitan Statistical Area such as a municipality, town, village, township, or community area, but does not include publications of professional and trade associations.

(d) The changes made to this Section by this amendatory Act of the 101st General Assembly shall apply to all applications submitted after the effective date of this amendatory Act of the 101st General Assembly.

(e) The changes made to this Section by this amendatory Act of the 104th General Assembly shall apply to any application for change of ownership or exemption filed on or after the effective date of this amendatory Act of the 104th General Assembly.

(Source: P.A. 103-526, eff. 1-1-24.)

(20 ILCS 3960/8.7)

(Section scheduled to be repealed on December 31, 2029)

Sec. 8.7. Application for permit for discontinuation of a health care facility or category of service; public notice and public hearing.

(a) Upon a finding that an application to close a health care facility or discontinue a category of service is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a

facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's website and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.

Before approving an application for closure or discontinuation, the Board shall require a Community Health Impact Assessment (CHIA) consistent with rules promulgated under Section 8.6 and shall not approve the application if the Board finds that the proposed closure or discontinuation will likely degrade essential health outcomes, worsen geographic access to emergent or urgent care, or impose an undue increase in travel time for ordinarily accessible services.

An application to close a health care facility shall only be deemed complete if it includes evidence that the health care facility provided written notice at least 30 days prior to filing the application of its intent to do so to the municipality in which it is located, the State Representative

and State Senator of the district in which the health care facility is located, the State Board, the Director of Public Health, and the Director of Healthcare and Family Services. The changes made to this subsection by this amendatory Act of the 101st General Assembly shall apply to all applications submitted after the effective date of this amendatory Act of the 101st General Assembly.

(b) No later than 30 days after issuance of a permit to close a health care facility or discontinue a category of service, the permit holder shall give written notice of the closure or discontinuation to the State Senator and State Representative serving the legislative district in which the health care facility is located.

(b-5) The Board shall monitor outcomes for a minimum of 5 years following any permitted closure or service reduction, including data reported annually on access, such as travel time and ambulance diversion), staffing levels, charity care, and community health indicators. Failure to submit required reports or materially breaching commitments shall subject the permit holder and any applicable owner to penalties and remedies under this Act.

(c)(1) If there is a pending lawsuit that challenges an application to discontinue a health care facility that either names the Board as a party or alleges fraud in the filing of the application, the Board may defer action on the application for up to 6 months after the date of the initial deferral of

the application.

(2) The Board may defer action on an application to discontinue a hospital that is pending before the Board as of the effective date of this amendatory Act of the 102nd General Assembly for up to 60 days after the effective date of this amendatory Act of the 102nd General Assembly.

(3) The Board may defer taking final action on an application to discontinue a hospital that is filed on or after January 12, 2021, until the earlier to occur of: (i) the expiration of the statewide disaster declaration proclaimed by the Governor of the State of Illinois due to the COVID-19 pandemic that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later; or (ii) the expiration of the declaration of a public health emergency due to the COVID-19 pandemic as declared by the Secretary of the U.S. Department of Health and Human Services that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later. This paragraph (3) is repealed as of the date of the expiration of the statewide disaster declaration proclaimed by the Governor of the State of Illinois due to the COVID-19 pandemic that is in effect on January 12, 2021, or any extension thereof, or July 1, 2021, whichever occurs later.

(d) The changes made to this Section by this amendatory Act of the 101st General Assembly shall apply to all applications submitted after the effective date of this

amendatory Act of the 101st General Assembly.

(Source: P.A. 101-83, eff. 7-15-19; 101-650, eff. 7-7-20; 102-4, eff. 4-27-21.)

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

(Section scheduled to be repealed on December 31, 2029)

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

(1) Prescribe rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of project reviewed and which are required to carry out the provisions and purposes of this Act. Policies and procedures of the State Board shall take into consideration the priorities and needs of medically underserved areas and other health care services, giving special consideration to the impact of projects on access to safety net services.

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

(3) (Blank).

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, maintain an updated inventory on

the Board's web site reflecting the most recent bed and service changes and updated need determinations when new census data become available or new need formulae are adopted, and develop health care facility plans which shall be utilized in the review of applications for permit under this Act. Such health facility plans shall be coordinated by the Board with pertinent State Plans. Inventories pursuant to this Section of skilled or intermediate care facilities licensed under the Nursing Home Care Act, skilled or intermediate care facilities licensed under the ID/DD Community Care Act, skilled or intermediate care facilities licensed under the MC/DD Act, facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013, or nursing homes licensed under the Hospital Licensing Act shall be conducted on an annual basis no later than July 1 of each year and shall include among the information requested a list of all services provided by a facility to its residents and to the community at large and differentiate between active and inactive beds.

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

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

(b) The number of existing and planned facilities

offering similar programs;

(c) The extent of utilization of existing facilities;

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

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

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

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

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

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

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

(6) Solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or

property for use by the State Board in the administration of this Act; and enter into contracts consistent with the appropriations for purposes enumerated in this Act.

(7) (Blank).

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

Substantive projects shall include no more than the following:

(a) Projects to construct (1) a new or replacement facility located on a new site or (2) a replacement facility located on the same site as the original facility and the cost of the replacement facility exceeds the capital expenditure minimum, which shall be reviewed by the Board within 120 days;

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

(c) Projects proposing a change in the bed capacity of a health care facility by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation

of beds from one physical facility or site to another by more than 20 beds or more than 10% of total bed capacity, as defined by the State Board, whichever is less, over a 2-year period.

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

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

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

(10) Prescribe rules, regulations, standards and criteria for the conduct of an expeditious review, not exceeding 60 days, of applications for permits for projects to construct or modify health care facilities

which are needed for the care and treatment of persons who have acquired immunodeficiency syndrome (AIDS) or related conditions.

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

(11) Issue written decisions upon request of the applicant or an adversely affected party to the Board. Requests for a written decision shall be made within 15 days after the Board meeting in which a final decision has been made. A "final decision" for purposes of this Act is the decision to approve or deny an application, or take other actions permitted under this Act, at the time and date of the meeting that such action is scheduled by the Board. The transcript of the State Board meeting shall be incorporated into the Board's final decision. The staff of the Board shall prepare a written copy of the final decision and the Board shall approve a final copy for inclusion in the formal record. The Board shall consider, for approval, the written draft of the final decision no later than the next scheduled Board meeting. The written decision shall identify the applicable criteria and factors listed in this Act and the Board's regulations that were taken into consideration by the Board when coming to a final decision. If the Board denies or fails to

approve an application for permit or exemption, the Board shall include in the final decision a detailed explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill.

(12) (Blank).

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

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

(15) Establish a separate set of rules and guidelines for long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities. An open and transparent process shall be developed that considers the following: how skilled nursing fits in the continuum of care with other care providers, modernization of nursing homes, establishment of more private rooms, development of alternative services, and current trends in long-term care services. The Chairman of the Board shall appoint a permanent Health Services Review Board Long-term Care Facility Advisory Subcommittee that shall develop and recommend to the Board the rules to be established by the Board under this paragraph (15). The Subcommittee shall also provide continuous review and commentary on policies

and procedures relative to long-term care and the review of related projects. The Subcommittee shall make recommendations to the Board no later than January 1, 2016 and every January thereafter pursuant to the Subcommittee's responsibility for the continuous review and commentary on policies and procedures relative to long-term care. In consultation with other experts from the health field of long-term care, the Board and the Subcommittee shall study new approaches to the current bed need formula and Health Service Area boundaries to encourage flexibility and innovation in design models reflective of the changing long-term care marketplace and consumer preferences and submit its recommendations to the Chairman of the Board no later than January 1, 2017. The Subcommittee shall evaluate, and make recommendations to the State Board regarding, the buying, selling, and exchange of beds between long-term care facilities within a specified geographic area or drive time. The Board shall file the proposed related administrative rules for the separate rules and guidelines for long-term care required by this paragraph (15) by no later than September 30, 2011. The Subcommittee shall be provided a reasonable and timely opportunity to review and comment on any review, revision, or updating of the criteria, standards, procedures, and rules used to evaluate project applications as provided under Section 12.3 of this Act.

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

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

(16) Prescribe the format of the State Board Staff Report. A State Board Staff Report shall pertain to applications that include, but are not limited to, applications for permit or exemption, applications for permit renewal, applications for extension of the financial commitment period, applications requesting a declaratory ruling, or applications under the Health Care

Worker Self-Referral Act. State Board Staff Reports shall compare applications to the relevant review criteria under the Board's rules.

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

number of authorized beds under this Act in facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 exceed the number of authorized beds on June 16, 2014 (the effective date of Public Act 98-651).

(18) Elect a Vice Chairman to preside over State Board meetings and otherwise act in place of the Chairman when the Chairman is unavailable.

(19) The Board may deny or impose conditions on any covered transaction, as defined in Section 8.6, when the Board determines that the transaction is likely to harm access to essential services or materially degrade community health outcomes.

(20) The Board may impose enforceable conditions on covered transactions or permits for discontinuation, including minimum staffing and service-level guarantees for a specified minimum period of 3 years, capital investment obligations, restrictions on dividend distributions and leveraged recapitalizations for a specified period, and binding community benefit agreements.

(21) The Board shall require disclosure of the full ownership chain and ultimate beneficial owners in all covered transaction filings and may require submission of financial documents under protective order. The Board shall adopt rules defining required disclosures and the

circumstances under which confidential treatment may be granted.

(Source: P.A. 100-518, eff. 6-1-18; 100-681, eff. 8-3-18; 101-83, eff. 7-15-19.)

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Statutes amended in order of appearance