SB2901

LRB10218526KTG26752b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB2901

Introduced 5/19/2021, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Public Aid Code. Provides that it shall be a matter of State policy that the Department of Healthcare and Family Services shall set nursing facility rates by rule utilizing an evidenced-based methodology that rewards appropriate staffing, quality-of-life improvements for nursing facility residents, including the cessation of payments for rooms with 3 or more people residing in them by January 1, 2027, and the reduction of racial inequities and health disparities for nursing facility residents enrolled in Medicaid. Provides that the new nursing services reimbursement methodology taking effect January 1, 2022, upon federal approval, shall utilize the Patient Driven Payment Model (PDPM) (rather than the RUG-IV 48 grouper model). Sets the statewide base rate for dates of service on and after January 1, 2022 at $85.25. Requires the Department to establish, by rule, a multiplier based on information from the Payroll Based Journal. Provides that, beginning on and after January 1, 2022, the Department shall allocate funding, by rule, for per diem add-ons to the PDPM methodology for each resident with a diagnosis of Alzheimer's disease. Contains provisions concerning funds allocated for certain incentive payments to nursing facilities; emergency rules; payments to improve the quality of care delivered by nursing facilities; long-term care provider assessments; and other matters. Amends the Nurse Agency Licensing Act. Prohibits nurse agencies from entering into covenants not to compete with certified nurse aides. Amends the Illinois Administrative Procedure Act. Permits the Department of Healthcare and Family Services to adopt emergency rules. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 3. The Illinois Administrative Procedure Act is amended by adding Section 5-45.8 as follows:

(5 ILCS 100/5-45.8 new)

Sec. 5-45.8. Emergency rulemaking; nursing facility payment rates. To provide for the expeditious and timely implementation of changes made to Section 5-5.2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly, emergency rules may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed on January 1, 2026.

Section 5. The Nurse Agency Licensing Act is amended by changing Sections 3 and 14 as follows:

(225 ILCS 510/3) (from Ch. 111, par. 953)

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

(a) "Certified nurse aide" means an individual certified

as defined in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, or Section 3-206 of the MC/DD Act, as now or hereafter amended.

(b) "Department" means the Department of Labor.

(c) "Director" means the Director of Labor.

(d) "Health care facility" is defined as in Section 3 of the Illinois Health Facilities Planning Act, as now or hereafter amended.

(e) "Licensee" means any nursing agency which is properly licensed under this Act.

(f) "Nurse" means a registered nurse or a licensed practical nurse as defined in the Nurse Practice Act.

(g) "Nurse agency" means any individual, firm, corporation, partnership or other legal entity that employs, assigns or refers nurses or certified nurse aides to a health care facility for a fee. The term "nurse agency" includes nurses registries. The term "nurse agency" does not include services provided by home health agencies licensed and operated under the Home Health, Home Services, and Home Nursing Agency Licensing Act or a licensed or certified individual who provides his or her own services as a regular employee of a health care facility, nor does it apply to a health care facility's organizing nonsalaried employees to provide services only in that facility.

(h) "Covenant not to compete" means an agreement between an employer and an employee that restricts such employee from

performing:

(1) any work for another employer for a specified period of time;

(2) any work in a specified geographical area; or

(3) work for another employer that is similar to such employee's work for the employer included as a party to the agreement.

(Source: P.A. 98-104, eff. 7-22-13; 99-180, eff. 7-29-15.)

(225 ILCS 510/14) (from Ch. 111, par. 964)

Sec. 14. Minimum Standards. (a) The Department, by rule, shall establish minimum standards for the operation of nurse agencies. Those standards shall include, but are not limited to: (1) the maintenance of written policies and procedures; and (2) the development of personnel policies which include a personal interview, a reference check, an annual evaluation of each employee (which may be based in part upon information provided by health care facilities utilizing nurse agency personnel) and periodic health examinations.

(b) Each nurse agency shall have a nurse serving as a manager or supervisor of all nurses and certified nurses aides.

(c) Each nurse agency shall ensure that its employees meet the minimum licensing, training, and orientation standards for which those employees are licensed or certified.

(d) A nurse agency shall not employ, assign, or refer for

use in an Illinois health care facility a nurse or certified nurse aide unless certified or licensed under applicable provisions of State and federal law or regulations. Each certified nurse aide shall comply with all pertinent regulations of the Illinois Department of Public Health relating to the health and other qualifications of personnel employed in health care facilities.

(e) The Department may adopt rules to monitor the usage of nurse agency services to determine their impact.

(f) Nurse agencies are prohibited from requiring, as a condition of employment, assignment, or referral, that their employees recruit new employees for the nurse agency from among the permanent employees of the health care facility to which the nurse agency employees have been employed, assigned, or referred, and the health care facility to which such employees are employed, assigned, or referred is prohibited from requiring, as a condition of employment, that their employees recruit new employees from these nurse agency employees. Violation of this provision is a business offense.

(g) Nurse agencies are prohibited from entering into covenants not to compete with certified nurse aides who are employed by the agencies. After the effective date of this amendatory Act of the 102nd General Assembly, a covenant not to compete entered into between a nurse agency and a certified nurse aide is illegal and void.

(Source: P.A. 86-817.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5-5.2, 5-5.4, 5B-2, 5B-4, 5B-5, 5B-8, and 5E-10 as follows:

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

Sec. 5-5.2. Payment.

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

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(b-1) It shall be a matter of State policy that the Illinois Department shall set nursing facility rates by rule utilizing an evidence-based methodology that rewards appropriate staffing, quality-of-life improvements for nursing facility residents, including the cessation of payments for rooms with 3 or more people residing in them by January 1, 2027, and the reduction of racial inequities and health disparities for nursing facility residents enrolled in Medicaid.

(c) (Blank). ~~Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a~~

~~new reimbursement system based on the Resource Utilization Groups (RUGs) has been fully operationalized, which shall take effect for services provided on or after January 1, 2014.~~

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model ~~RUG-IV 48 grouper model~~, which shall be referred to as the PDPM ~~RUGs~~ reimbursement system, taking effect January 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services, ~~2014,~~ shall be based on the following:

(1) The methodology shall be resident-centered ~~resident-driven~~, facility-specific, and based on guidance from the Centers for Medicare and Medicaid Services ~~cost-based~~.

(2) ~~Costs shall be annually rebased and case mix index quarterly updated.~~ The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

(3) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on January 1, 2022 ~~April 30, 2012~~ shall be included.

(4) PDPM nursing case-mix indices in effect on May 1, 2021 ~~Case mix index~~ shall be assigned to each resident

class based on the Centers for Medicare and Medicaid Services staff time measurement study called Staff Time And Resource Intensity Verification (STRIVE) ~~in effect on July 1, 2013~~, adjusted by a uniform multiplier to achieve the same statewide case mix index value observed for the quarter beginning April 1, 2021 while holding PA1, PA2, BA1, and BB1 resident classes at the level applicable under the RUG-IV payment model prior to January 1, 2022. ~~utilizing an index maximization approach.~~

(5) (Blank). ~~The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).~~

(6) The statewide base rate for dates of service on and after January 1, 2022 shall be $85.25.

(7) The Department shall establish, by rule, a multiplier based on information from the most recent available federal staffing report, currently the Payroll Based Journal, adjusted for acuity if applicable using the same quarter's MDS. The multiplier may not exceed 1.0 unless the nursing facility is at least at 92% of the STRIVE study in effect on May 1, 2021.

(d-1) (Blank). ~~Calculation of base year Statewide RUG-IV nursing base per diem rate.~~

~~(1) Base rate spending pool shall be:~~

~~(A) The base year resident days which are~~

~~calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.~~

~~(B) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by subsection (A).~~

~~(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph (5).~~

~~(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:~~

~~(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).~~

~~(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.~~

~~(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.~~

~~(D) The sum of the products calculated for each~~

~~nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.~~

~~(3) The Statewide RUG-IV nursing base per diem rate:~~

~~(A) on January 1, 2014 shall be the quotient of the paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2); and~~

~~(B) on and after July 1, 2014, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76.~~

~~(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.~~

~~(5) Nursing facilities designated as of July 1, 2012 by the Department as "Institutions for Mental Disease" shall be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.~~

(e) Beginning July 1, 2014 through December 31, 2021, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to the RUGS methodology for dates of service on and after July 1, 2014:

(1) $0.63 for each resident who scores in I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

(2) $2.67 for each resident who scores either a "1" or

"2" in any items S1200A through S1200I and also scores in RUG groups PA1, PA2, BA1, or BA2.

(3) Beginning on and after January 1, 2022, the Department shall allocate funding, by rule, for per diem add-ons to the PDPM methodology for each resident with a diagnosis of Alzheimer's disease.

(e-1) (Blank).

(e-2) (Blank). ~~For dates of services beginning January 1, 2014, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014 shall be as follows:~~

~~(1) The transition RUG-IV per diem nursing rate for nursing homes whose rate calculated in this subsection (e-2) is greater than the nursing component rate in effect July 1, 2012 shall be paid the sum of:~~

~~(A) The nursing component rate in effect July 1, 2012; plus~~

~~(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.88.~~

~~(2) The transition RUG-IV per diem nursing rate for nursing homes whose rate calculated in this subsection~~

~~(c-2) is less than the nursing component rate in effect July 1, 2012 shall be paid the sum of:~~

~~(A) The nursing component rate in effect July 1, 2012; plus~~

~~(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.13.~~

(f) Notwithstanding any other provision of this Code, on and after July 1, 2012, reimbursement rates associated with the nursing or support components of the current nursing facility rate methodology shall not increase beyond the level effective May 1, 2011 until a new reimbursement system based on the RUGs IV 48 grouper model has been fully operationalized.

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) Individual nursing rates for residents classified in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter ending March 31, 2012 shall be reduced by 10%;

(2) Individual nursing rates for residents classified in all other RUG IV groups shall be reduced by 1.0%;

(3) Facility rates for the capital and support

components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(j) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish<u>, through December 31, 2021 or upon implementation of the staffing multiplier payments under paragraph (7) of subsection (d), whichever is later,</u> a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of

addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning January 1, 2022, or upon implementation of the staffing multiplier payments under paragraph (7) of subsection (d), whichever is later, the annual $70,000,000 described in the preceding sentence shall be dedicated to the staffing multiplier payments under paragraph (7) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services ~~and taking into account subsection (i)~~.

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be

used to increase each facility's rate by an equal percentage.

In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 102nd General Assembly, emergency rules to implement any provision of this amendatory Act of the 102nd General Assembly may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.

~~To implement item (i) in this subsection, facilities shall file quarterly reports documenting compliance with its annually approved staffing plan, which shall permit compliance with Section 3-202.05 of the Nursing Home Care Act. A facility that fails to meet the benchmarks and dates contained in the plan may have its add-on adjusted in the quarter following the quarterly review. Nothing in this Section shall limit the ability of the facility to appeal a ruling of non-compliance and a subsequent reduction to the add-on. Funds adjusted for noncompliance shall be maintained in the Long-Term Care Provider Fund and accounted for separately. At the end of each fiscal year, these funds shall be made available to facilities for special staffing projects.~~

~~In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 101st General Assembly, emergency rules to implement any provision of this amendatory Act of the 101st General Assembly may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The agency shall simultaneously file emergency rules and permanent rules to ensure that there is no interruption in administrative guidance. The 150 day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection, and the effective period may continue through June 30, 2021. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.~~

(k) ~~(j)~~ During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must

consider a revised reimbursement methodology that takes into account transparency, accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) The Department shall establish, by rule, payments to improve the quality of care delivered by facilities, including:

(1) Incentive payments determined by facility performance on specified quality measures, including, but not limited to, the consistent assignment of staff and staff retention.

(2) Incentive payments for infection control and facility modifications in support of a transition to the cessation of payment for facility rooms in which 3 or more people reside by January 1, 2027.

(3) Payments based on CNA tenure, professional development, and wage thresholds for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. For purposes of this paragraph, "CNA" means certified nurse aide.

(m) The Department shall utilize any federal monies allocated for nursing facilities under the American Rescue

Plan Act of 2021 or any other similar COVID-response funds for payments to enhance the quality of life of facility residents or to support workforce development initiatives for nursing facility staff.

(Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19; revised 9-18-19.)

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

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

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

facilities shall be based upon projected budgets. The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994, unless specifically provided for in this Section. The changes made by Public Act 93-841 extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

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

shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive staff. For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities the rates taking effect within 30 days after July 6, 2017 (the effective date of Public Act 100-23) shall include an increase sufficient to provide a $0.75 per hour wage increase for non-executive staff. The Department shall adopt rules, including emergency rules under subsection (y) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph. For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, the rates taking effect within 30 days after the effective date of this amendatory Act of the 100th General Assembly shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive front-line personnel, including, but not limited to, direct support persons, aides, front-line supervisors, qualified intellectual disabilities professionals, nurses, and non-administrative support staff. The Department shall adopt rules, including emergency rules under subsection (bb) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the

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

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

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now

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

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

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

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

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

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

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

December 31, 2006:

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

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

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

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on January 1, 2008 shall be computed using the most recent cost reports on file with the Department of

Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.

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

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

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

2002.

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

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

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

shall be increased to the amount that would have been derived using standard Department of Healthcare and Family Services methods, procedures, and inflators.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, or facilities licensed by the Department of Public Health under the Specialized Mental Health Rehabilitation Act of 2013, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate shall be increased by a factor of 2.53 on the first day of the month that begins at least 45 days after January 11, 2008 (the effective date of Public Act 95-707). As of August 1, 2008, the socio-development component rate shall be equal to 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53. For services provided on or after April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, whichever is later, the Illinois Department may by rule adjust these socio-development component rates, and may use different adjustment methodologies for those facilities participating, and those not participating, in the Illinois Department's demonstration

program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, but in no case may such rates be diminished below those in effect on August 1, 2008.

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

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

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

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

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

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

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

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

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

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

The Department shall develop enhanced payments to offset the additional costs incurred by a facility serving exceptional need residents and shall allocate at least $4,000,000 of the funds collected from the assessment established by Section 5B-2 of this Code for such payments.

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

Beginning January 1, 2014 the methodologies for reimbursement of nursing facility services as provided under this Section 5-5.4 shall no longer be applicable for services provided on or after January 1, 2014.

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

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

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval, the rates taking effect for services delivered on or after August 1, 2019 shall be increased by 3.5% over the rates in effect on June 30, 2019. The Department shall adopt rules, including emergency rules under subsection (ii) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval, the rates taking effect on the latter of the

approval date of the State Plan Amendment for these facilities or the Waiver Amendment for the home and community-based services settings shall include an increase sufficient to provide a $0.26 per hour wage increase to the base wage for non-executive staff. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

For facilities licensed by the Department of Public Health under the ID/DD Community Care Act as ID/DD Facilities and under the MC/DD Act as MC/DD Facilities, subject to federal approval of the State Plan Amendment and the Waiver Amendment for the home and community-based services settings, the rates taking effect for the services delivered on or after July 1, 2020 shall include an increase sufficient to provide a $1.00 per hour wage increase for non-executive staff. For services delivered on or after January 1, 2021, subject to federal approval of the State Plan Amendment and the Waiver Amendment for the home and community-based services settings, shall include an increase sufficient to provide a $0.50 per hour increase for non-executive staff. The Department shall adopt rules, including emergency rules as authorized by Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section, including wage increases for direct care staff.

(Source: P.A. 100-23, eff. 7-6-17; 100-587, eff. 6-4-18; 101-10, eff. 6-5-19; 101-636, eff. 6-10-20.)

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

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

(a) For the privilege of engaging in the occupation of long-term care provider, beginning July 1, 2011 through December 31, 2021, or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1), whichever is later, an assessment is imposed upon each long-term care provider in an amount equal to $6.07 times the number of occupied bed days due and payable each month. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider.

(a-1) For the privilege of engaging in the occupation of long-term care provider, beginning January 1, 2022, an assessment is imposed upon each long-term care provider in an amount equal to $17 times the number of occupied bed days due and payable each month. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Implementation of the assessment described in this subsection

shall be subject to federal approval by the Centers for Medicare and Medicaid Services.

(a-2) Every 6 months the Department shall calculate the payments to nursing facilities under Section 5-5.2. If the State share of those payments for the 6-month period calculated exceeds the average nursing rate payment per resident in effect on June 30, 2019, the Department may increase the assessment described in subsection (a-1) for the next 6 months to an amount that will generate the State share sufficient to cover the increased cost, as long as the revenue generated from the assessment does not exceed the federal cap as established by the Centers for Medicare and Medicaid Services. The Department shall notify each facility subject to the assessment of the adjusted rate at least 30 days prior to the date upon which the new rate takes effect and any new rate imposed on the facilities shall take effect at the start of the 6-month period that begins 6 months after the period used to calculate the new rate.

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

(c) The assessment imposed by this Section shall not be

due and payable, however, until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.4 of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and that the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(Source: P.A. 96-1530, eff. 2-16-11; 97-10, eff. 6-14-11; 97-584, eff. 8-26-11.)

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

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

(a) The assessment imposed by Section 5B-2 shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment

obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

(a-5) The Illinois Department shall provide for an electronic submission process for each long-term care facility to report at a minimum the number of occupied bed days of the long-term care facility for the reporting period and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code. Beginning July 1, 2013, a separate electronic submission shall be completed for each long-term care facility in this State operated by a long-term care provider. The Illinois Department shall provide a self-reporting notice of the assessment form that the long-term care facility completes for the required period and submits with its assessment payment to the Illinois Department. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

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

for services provided during the month on which the assessment is levied ~~or the Medicaid managed care organization has not been paid by the State~~.

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

(c-5) If a long-term care facility fails to file its assessment bill with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due. After July 1, 2013, no penalty shall be assessed under this Section if the Illinois Department does not provide a process for the electronic submission of the

information required by subsection (a-5).

(d) Nothing in this amendatory Act of 1993 shall be construed to prevent the Illinois Department from collecting all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

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

(f) No installment of the assessment imposed by Section 5B-2 shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.2 ~~5-5.4~~ of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.2 ~~5-5.4~~ of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the

Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.2 ~~5-5.4~~ of this Code.

(Source: P.A. 100-501, eff. 6-1-18; 101-649, eff. 7-7-20.)

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

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

(a) After December 31 of each year, and on or before March 31 of the succeeding year, every long-term care provider subject to assessment under this Article shall file a report with the Illinois Department. The report shall be in a form and manner prescribed by the Illinois Department and shall state the revenue received by the long-term care provider, reported in such categories as may be required by the Illinois Department, and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code.

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

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

long-term care facility in respect of which the person is subject to assessment under this Article as a long-term care provider, the person shall file a final, amended return with the Illinois Department not more than 90 days after the cessation reflecting the adjustment and shall pay with the final return the assessment for the year as so adjusted (to the extent not previously paid). If a person fails to file a final amended return on a timely basis, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(d) Notwithstanding any other provision of this Article, a provider who commences operating or maintaining a long-term care facility that was under a prior ownership and remained licensed by the Department of Public Health shall notify the Illinois Department of any ~~the~~ change in ownership regardless of percentage, and shall be responsible to immediately pay any prior amounts owed by the facility. In addition, within 90 days after the effective date of this amendatory Act of the 102nd General Assembly, all providers operating or maintaining a long-term care facility shall notify the Illinois Department of all owners of that facility and the percentage ownership of each owner.

(e) The Department shall develop a procedure for sharing with a potential buyer of a facility information regarding outstanding assessments and penalties owed by that facility.

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

(g) If a long-term care provider fails to file its return on or before the due date of the return, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty assessment equal to 25% of the assessment imposed for the year. After July 1, 2013, no penalty shall be assessed if the Illinois Department has not established a process for the electronic submission of information.

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

(i) The Illinois Department shall establish a process for long-term care providers to electronically submit all information required by this Section no later than July 1, 2013.

(Source: P.A. 96-1530, eff. 2-16-11; 97-403, eff. 1-1-12; 97-813, eff. 7-13-12.)

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

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

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

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

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

(1.5) For payments to managed care organizations as defined in Section 5-30.1 of this Code.

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

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

(3.5) For reimbursement of expenses incurred by long-term care facilities, and payment of administrative expenses incurred by the Department of Public Health, in relation to the conduct and analysis of background checks

for identified offenders under the Nursing Home Care Act.

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

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

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

(7) For making transfers, at the direction of the Director of the Governor's Office of Management and Budget during each fiscal year beginning on or after January 1, 2022, to the Healthcare Provider Relief Fund in an annual amount of $49,000,000 of the tax collected pursuant to this Article for the purpose of enforcement of nursing home standards, payments for other long-term care priorities of the Department, including payments to managed care organizations, and efforts to expand home and community-based services. For the 6-month period during State Fiscal Year 2022, on and after January 1, 2022 through June 30, 2022, the amount listed above shall be prorated to an amount of 1/12th per month.

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

(c) The Fund shall consist of the following:

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

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

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

(4) (Blank).

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

(Source: P.A. 96-1530, eff. 2-16-11; 97-584, eff. 8-26-11.)

(305 ILCS 5/5E-10)

Sec. 5E-10. Fee. Through December 31, 2021 or upon federal approval by the Centers for Medicare and Medicaid Services of the long-term care provider assessment described in subsection (a-1) of Section 5B-2 of this Code, whichever is later, every ~~Every~~ nursing home provider shall pay to the Illinois Department, on or before September 10, December 10, March 10, and June 10, a fee in the amount of $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. This fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. All fees received by the Illinois Department under this Section shall be deposited into the Long-Term Care Provider Fund.

(Source: P.A. 88-88; 89-21, eff. 7-1-95.)

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

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