AN ACT in relation to health.

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

Section 1. Short title. The Act may be cited as the Local Health Care Accountability Act.

Section 5. Findings. The General Assembly finds that:

(1) Access to health care services is of vital concern to the people of this State. Notwithstanding public and private efforts to increase access to health care, the people of this State continue to have tremendous unmet health needs.

(2) The State has a substantial interest in ensuring that the unmet health needs of its residents are addressed. Health care institutions can help address needs by providing community benefits to the uninsured and underinsured members of their communities. Health care services providers play an important role in providing essential health care services in the communities they serve.

(3) Illinois has a proud history of non-profit health care facilities and philanthropic support of medical services, education, and research.

(4) Health care facilities in Illinois provide overall high quality care at a reasonable cost. Health care facilities in Illinois have experienced during the 1990s substantial declines in occupancy as the health care system has changed. Health care facilities require capital to maintain operations and to modernize facilities and services.

(5) Nationally and regionally, private investment is being made that results in the conversion of

not-for-profit and public health care facilities into for-profit health care facilities. There are health care facilities in Illinois that have provided and continue to provide important services to communities that submit that their survival may depend on the ability to enter into agreements that result in the investment of private capital and their conversion to for-profit status.

(6) Health care facilities, both for-profit and not-for-profit, are merging and forming networks to achieve integration, stability and efficiency and the presence of such networks affects competition.

(7) There are concerns that health care facility networks may engage in practices that affect the quality of medical services for the community as a whole and for the vulnerable members of society in particular. In order to protect the public health and welfare and public and charitable assets, it is necessary to establish standards and procedures for health care facility conversions.

(8) Delivery of quality health care services is jeopardized and patients in Illinois health care facilities are being adversely impacted by inadequate and poorly monitored staffing practices.

(9) The basic principles of staffing in health care facilities should be focused on the patients' care needs deriving from the severity and complexity of each patient's condition and the services that need to be provided to ensure optimal outcomes.

The legislature further concludes that licensing privileges conveyed by this State to health care facilities for the right to conduct intrastate business should be accompanied by concomitant obligations to address unmet health care needs. These obligations should be clearly delineated. Community benefits should become a recognized and accepted obligation of all health care facilities in this

State. Accordingly, every licensed health care facility must provide community benefits in a manner set forth in this Act.

Section 10. Purposes. The purposes of this Act are as follows:

(1) To ensure accessible, affordable and high quality health care for all Illinois residents.

(2) To establish a process to evaluate, monitor and review whether the trend of for-profit corporations gaining an interest in health care facilities will maintain, enhance, or disrupt the delivery of health care in this State and to monitor health care facility performance to ensure that standards for community benefits continue to be met.

(3) To establish a review process and criteria for review of conversions which involve for-profit corporations.

(4) To establish a review process and criteria for review of conversions which involve only not-for-profit corporations.

(5) To clarify the jurisdiction and authority of the Illinois Health Facilities Planning Board and the Illinois Department of Public Health to protect public health and welfare and the jurisdiction and authority of the Illinois Attorney General to preserve and protect public and charitable assets in reviewing both conversions that involve for-profit corporations and conversions that involve only not-for-profit corporations.

(6) To provide for independent foundations to hold and distribute proceeds of conversions consistent with the acquiree's original purpose or for the support and promotion of health care and social needs in the affected community.

Section 15. Definitions. For purposes of this Act, unless the context requires otherwise:

"Acquiree" means the person or persons who lose any ownership or control in the new health care facility.

"Acquiror" means the person or persons who gain an ownership or control in the new health care facility.

"Affected community" means any county, township, municipality, or otherwise identifiable geographic region in which an existing health care facility is physically located or whose inhabitants are regularly served by the existing health care facility.

"Bad debt" means the unpaid accounts of any individual who has received medical care or is financially responsible for the cost of care rendered to another, if the individual has the ability to pay and has refused to pay.

"Board" means the Illinois Health Facilities Planning Board.

"Charity care" means health care services provided by a health care facility without charge to a patient and for which the health care facility does not expect and has not expected payment.

"Community" means the geographic service area or areas and patient population or populations that a health care facility serves.

"Community benefits" means the unreimbursed goods, services, and resources provided by a health care facility that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Community benefits include but are not limited to the following:

(1) Free care.

(2) Public education and other programs relating to preventive medicine or the public health of the community.

(3) Health or disease screening programs.

(4) Transportation services.

(5) Poison control centers.

(6) Donated medical supplies and equipment.

(7) Unreimbursed costs of providing services to persons participating in any government subsidized health care program.

(8) Free or below-cost blood banking services.

(9) Free or below-cost assistance, material, equipment, and training to emergency medical services and ambulance services.

(10) The costs to implement a basic enrollment program that provides a package of primary care services to uninsured members of the community.

(11) Health research, education and training programs, provided that they are related to identified health needs.

"Conversion" means any transfer by a person or persons of an ownership or membership interest or authority in a health care facility, or the assets of such a facility, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition that results in a change of ownership, control, or possession of 20% or greater of the membership or voting rights or interests of the health care facility, or the removal, addition, or substitution of a partner that results in a new partner gaining or acquiring a controlling interest in the facility, or any change in membership that results in a new person gaining or acquiring a controlling vote in the facility.

"Department" means the Illinois Department of Public Health.

"Director" means the Director of Public Health.

"Employment displacement" means permanent termination of employment, a layoff or furlough of more than 30 days

duration, a significant cut-back in paid work hours, or any other comparable action that impacts employment status, except that the term does not include a discharge or termination for cause.

"Existing health care facility" means a health care facility as it exists before an acquisition.

"For-profit corporation" means a legal entity formed for the purpose of pecuniary profit or transacting business that has as one of its purposes pecuniary profit.

"Free care" means care provided by a health care services provider to patients unable to pay and for which the provider has no expectation of payment from the patient or from any third-party payor.

"Health care facility" means: an individual, sole proprietor, partnership, association, business trust, or corporation, whether for-profit or not-for-profit, that does any of the following:

(1) Provides health care services at an ambulatory surgical treatment center licensed under the Ambulatory Surgical Treatment Center Act; an institution, place, building, or agency licensed under the Hospital Licensing Act; an institution licensed under the Nursing Home Care Act; or a kidney disease treatment center licensed by the State.

(2) Provides health care services to a facility identified in paragraph (1).

(3) Provides necessary related services, including administrative, food service, janitorial, or maintenance services, to a health care facility identified in paragraph (1).

An entity that solely manufactures or provides goods or equipment to a health care facility shall not thereby be deemed a health care facility.

"New health care facility" means a health care facility

as it exists after the completion of a conversion.

"Not-for-profit corporation" means a legal entity formed for some charitable or benevolent purpose and not for profit that has been exempted from taxation pursuant to the Internal Revenue Code, Section 501(c)(3).

"Payment in lieu of taxes" means an agreement with a taxing body that, in the last year immediately before a conversion under this Act, levied real estate taxes on all or any portion of the real estate or leaseholds owned or leased by the for-profit entity seeking a conversion with a not-for-profit entity under this Act.

"Taxing body" means a public body that has the legal authority to levy real estate taxes on all or any portion of the real estate or leaseholds owned or leased by any for-profit corporation or for-profit entity seeking approval for a conversion under this Act.

"Transacting party" means any person or persons who seek either to transfer or acquire ownership or a controlling interest or controlling authority in a health care facility that would result in a change of ownership, control, or authority of 20% or greater.

"Uncompensated care" means a combination of free care, which the health care facility provides at no cost to the patient, bad debt that the health care facility bills for but does not collect, and less than full Medicaid reimbursement amounts.

Section 20. Conversion; prior approval process.

(a) No conversion may take place involving a not-for-profit corporation as either the acquiror or acquiree without the prior approval of both the Attorney General and the Illinois Health Facilities Planning Board. The parties to the conversion shall file an initial application with the Attorney General and the Board on a form prescribed by the

Attorney General. At a minimum, the form must include the following information with respect to each transacting party and the proposed new health care facility:

(1) A detailed summary of the proposed conversion.

(2) The names, addresses, and telephone numbers of the transacting parties.

(3) The names, addresses, telephone numbers, and occupations of all officers, members of the board of directors, trustees, and executive and senior level management personnel, including, for each position, the person currently holding the position and persons holding the position for the 3 years preceding the date of the application.

(4) Articles of incorporation and certificate of incorporation; and bylaws and organizational charts.

(5) Organizational structure for existing transacting parties and each partner, affiliate, parent, subsidiary, or related corporate entity in which the acquiror has a 20% or greater ownership interest.

(6) Conflict of interest statements, policies, and procedures.

(7) Names, addresses, and telephone numbers of professional consultants engaged in connection with the proposed conversion.

(8) Copies of audited income statements, balance sheets, and other financial statements for the 3 years immediately preceding the year in which the application is filed, to the extent they have been made public; audited interim financial statements and income statements together with a detailed description of the financing structure of the proposed conversion, including equity contribution, debt restructuring, stock issuance, partnership interests, stock offerings, and the like.

(9) A detailed description of real estate issues,

including title reports for land owned and lease agreements concerning the proposed conversion.

(10) A detailed description, as each relates to the proposed transaction, for: equipment leases, insurance, regulatory compliance, tax status, pending litigation or regulatory proceedings, pension plan descriptions and employee benefits, environmental reports, assessments, and organizational goals.

(11) Copies of reports analyzing the proposed conversion during the preceding 3 years, including, but not limited to, reports by appraisers, accountants, investment bankers, actuaries, and other experts.

(12) A description of the manner in which the price was determined, including methods of valuation and data used, and the names and addresses of persons preparing the documents; this information is deemed to be proprietary.

(13) Patient statistics for the preceding 3 years and patient projections for the next year, including patient visits, admissions, emergency room visits, clinical visits, and visits to each department of the facility, admissions to nursing care, and visits by affiliated home health care providers.

(14) The name and mailing address of each licensed facility in which the for-profit corporation maintains an ownership interest, controlling interest, or operating authority.

(15) A list of pending or adjudicated citations, violations, or charges against the facilities brought by any governmental agency or accrediting agency within the preceding 3 years, and the status or disposition of each matter with regard to patient care and charitable asset matters.

(16) A list of uncompensated care provided during

the preceding 3 years by each facility, including detail as to how that amount was calculated.

(17) Copies of all documents related to identification of all charitable assets, accounting of all charitable assets for the preceding 3 years, and distribution of the charitable assets, including, but not limited to, endowments and restricted, unrestricted, and specific-purpose funds, as each relates to the proposed transaction.

(18) A description of charity care and uncompensated care provided by the existing health care facility for the 5 years preceding the date of the application, including the cash value of those services and a description of services provided.

(19) A description of bad debt incurred by the existing health care facility for the preceding 5 years for which payment was anticipated but not received.

(20) A plan describing how the new health care facility will provide community benefits, as defined by this Act, and charity care during the first 5 years of operation.

(21) A description of how the new health care facility will monitor and value charity care services and community benefits.

(22) The names of persons currently serving as officers, directors, board members, or senior level managers of the existing health care facility who will or will not maintain any position with the new health care facility, and whether any such person will receive a salary, severance stock offering, or current or deferred compensation as a result of or in relation to the proposed conversion.

(23) A plan describing how the new health care facility will be staffed during the first 3 years of

operation.

(24) A list of all medical services, departments, clinical services, and administrative services that will be maintained at the new health care facility.

(25) A description of criteria established by the board of directors of the existing health care facility for pursuing a proposed conversion with one or more health care providers.

(26) All requests for proposals issued by the existing health care facility relating to the pursuit of a proposed conversion.

(27) A copy of all proposed contracts or arrangements with management, board members, officers, or directors of the existing health care facility for post-conversion consulting services or covenants not to compete following the completion of the conversion.

(28) Copies of documents or descriptions of any proposed plan for an entity to be created for charitable assets, including, but not limited to, endowments and restricted, unrestricted, and specific-purpose funds, the proposed articles of incorporation, by-laws, mission statement, program agenda, method of appointment of board members, qualifications of board members, duties of board members, and conflict of interest policies.

(29) A description of all departments and clinical, social, or other services or medical services that will be eliminated or significantly reduced at the new health care facility.

(30) A description of staffing levels of all categories of employees, including full-time, part-time, and contractual employees currently employed at or providing services at the existing health care facility, and a description of any anticipated or proposed changes in the current staffing levels.

(31) Signed conflict of interest forms from all officers, directors, trustees, senior level managers, chairpersons or department chairpersons, and medical directors on a form prescribed by the Attorney General.

(32) A statement of the expected impact the proposed action will have on the individual workforces of each affected health care facility.

(33) A statement that the expected workforce impact has been discussed with the affected employees and, in the case of employees who are represented by a duly certified or recognized bargaining representative, that the health care facility has met its legal obligations to negotiate regarding the impact with that bargaining representative.

(34) A separate certification from each member of the governing board and from the chief executive and each operating and financial officer of the corporation that is a party to the proposed conversion, executed under oath:

(A) Stating whether that director, chief executive, or operating or financial officer of the corporation is then or may become, within the 3-year period following the completion of the transaction, a member or shareholder in or an officer, employee, agent, or consultant of, or will otherwise derive any compensation or benefits, directly or indirectly, from the acquiring entity or any related party in connection with or as a result of the disposition.

(B) Disclosing any financial interest held by that individual or that individual's family or held by any business in which the individual or a member of the individual's family owns a financial interest in any financial transaction within the prior 24

months with any of the parties participating in the conversion.

(C) Stating that the market value of the health care facility's assets has not been manipulated to decrease or increase value.

(D) Stating that the terms of the transaction are fair and reasonable.

(E) Stating that the proceeds of the transaction will be used solely in a manner consistent with the charitable purposes of the not-for-profit corporation.

(F) Stating that the conversion will not adversely affect the availability or accessibility of health care services in the county or municipality in which the existing health care facility or facilities are located.

This certification requirement is not applicable, however, to any governing board member who votes to oppose the proposed conversion and has submitted a statement to that effect to the Illinois Health Facilities Planning Board and the Attorney General.

If the acquiror is a for-profit corporation that has acquired a not-for-profit health care facility under this Act, the application must also include a complete statement of performance during the preceding year with regard to the terms and conditions of approval of conversion and each projection, plan, or description submitted as part of the application for any conversion completed pursuant to an application submitted under this Act and made a part of an approval for the conversion. Two copies each of the initial application must be provided to the Illinois Health Facilities Planning Board and the Attorney General simultaneously by certified United States mail, return receipt requested.

(b) Except for the information determined by the Attorney General to be confidential or proprietary in accordance with subsection (g) of Section 7 of the Freedom of Information Act, the initial application and supporting documentation shall be considered public records and shall be available to the public for inspection upon request. The Attorney General shall provide access to these records at no cost to the public.

(c) The Attorney General may charge the parties to the conversion for the cost of providing the public with notice and reasonable access to records relating to the proposed conversion.

Section 25. Application review process; Attorney General.

(a) The Attorney General shall review all conversion applications involving a not-for-profit corporation as the acquiror or acquiree as follows:

(1) Within 10 business days after receipt of 2 copies of an initial application, the Attorney General must publish notice of the application in a newspaper of general circulation in the State and shall notify by United States mail any person who has requested notice of the filing of the application. The notice must state that an initial application has been received, the names of the transacting parties, the date by which a person may submit written comments to the Attorney General, and the date, time, and place of the public hearings on the application.

(2) No later than 45 days after the Attorney General has received the initial application for approval of a conversion involving a not-for-profit corporation as the acquiror or acquiree, the Attorney General must hold at least one public hearing in the service area of the acquiree health care facility. The number of public

hearings that the Attorney General holds must be appropriate to the size of the community in the health care facility's service area and the nature and value of the conversion to ensure that the community affected by the conversion has a meaningful opportunity to participate in the public hearing process. Upon request, any person must be given an opportunity to submit into the hearing record written comments, documents, and other exhibits and to offer oral testimony.

(3) Each party to the conversion must have a representative in attendance at all public hearings convened by the Attorney General under this Section.

(4) At least 21 days before the public hearing, the Attorney General must provide written notice of the time and place of the hearing through publication in one or more newspapers of general circulation in the affected communities, to the board of supervisors of the county in which the facility is located, and to all those who requested notice of the transaction.

(5) The Attorney General must establish and maintain a summary of written and oral comments made in preparation for and at the public hearing, including all questions posed, and must require answers of the appropriate parties. The summary and answers must be filed in the office of the Attorney General and made available for inspection at all public libraries located in the communities served by the acquiree health care facility. The Attorney General must also make a copy available for inspection upon request.

(6) As part of the public hearing process, the Attorney General must solicit comments and input regarding the criteria set forth in subsection (b) of this Section.

(7) The Attorney General has the power to subpoena

additional information or witnesses, require and administer oaths, and require sworn statements at any time before making a decision on an application.

(8) Within 30 days after receipt of an initial application, the Attorney General must advise the applicants in writing whether the application is complete and, if it is not, must specify the additional information that is required.

(9) Upon receipt of the additional information requested, the Attorney General must notify the applicants in writing of the date of the completed application.

(10) The Attorney General must approve, approve with conditions directly related to the proposed conversion, or disapprove the application within 120 days after the date of the completed application.

(11) Immediately upon making a determination on the application, the Attorney General must transmit a copy of his or her final determination to the Department.

(b) In reviewing an application pursuant to this Section, the Attorney General must consider the following criteria:

(1) Whether the proposed conversion will harm the public interest in trust property located or administered in this State and given, devised, or bequeathed to the existing health care facility for charitable, educational, or religious purposes.

(2) Whether a trustee or trustees of any charitable trust located or administered in this State will be deemed to have exercised reasonable care, diligence, and prudence in performing as a fiduciary in connection with the proposed conversion.

(3) Whether the governing board of the not-for-profit entity or entities, whether the acquiror,

acquiree, or both, established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes.

(4) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, formulated and issued appropriate requests for proposals in pursuing a conversion.

(5) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes.

(6) Whether any conflict of interest exists concerning the proposed conversion relative to members of the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, officers, directors, senior level managers, or experts or consultants engaged in connection with the proposed conversion, including, but not limited to, attorneys, accountants, investment bankers, actuaries, health care experts, or industry analysts.

(7) Whether individuals were provided with contracts or consulting agreements or arrangements that included pecuniary rewards based in whole or in part on the contingency of the completion of the conversion.

(8) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, exercised due care in engaging consultants with the appropriate level of independence, education, and experience in similar conversions.

(9) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, exercised due care in accepting assumptions and conclusions provided by consultants

engaged to assist in the proposed conversion.

(10) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, exercised due care in assigning a value to the existing health care facility and its charitable assets in proceeding to negotiate the proposed conversion.

(11) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, exposed an inappropriate amount of assets by accepting, in exchange for the proposed conversion, future or contingent value based upon success of the new health care facility.

(12) Whether members of the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, officers, directors, or senior level managers will receive future contracts in existing, new, or affiliated health care facilities or foundations.

(13) Whether any members of the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, will retain any authority in the new health care facility.

(14) Whether the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, accepted fair consideration and value for any management contracts made part of the proposed conversion.

(15) Whether individual members of the governing board of the not-for-profit entity or entities, whether the acquiror, acquiree, or both, officers, directors, or senior level managers engaged legal counsel to consider their individual rights or duties in acting in their capacity as a fiduciary in connection with the proposed conversion.

(16) Whether the proposed conversion results in an abandonment of the original purposes of the existing health care facility or whether a resulting entity will depart from the traditional purposes and mission of the existing facility such that a cy pres proceeding would be necessary.

(17) Whether the proposed conversion contemplates the appropriate and reasonable fair market value.

(18) Whether the proposed conversion was based on appropriate valuation methods, including, but not limited to, market approach, third party report, or fairness opinion.

(19) Whether the conversion is proper under the General Not-for-Profit Corporation Act of 1986.

(20) Whether the conversion is proper under the applicable State revenue Acts.

(21) Whether the proposed conversion jeopardizes the tax status of the existing health care facility.

(22) Whether the individuals who represented the existing health care facility in negotiations avoided conflicts of interest.

(23) Whether officers, board members, directors, or senior level managers deliberately acted or failed to act in a manner that impacted negatively on the value or purchase price.

(24) Whether the formula used in determining the value of the existing health care facility was appropriate and reasonable, which may include, but need not be limited to: factors such as the multiple factors applied to earnings before interest, taxes, depreciation, and amortization; the time period of the evaluation; price/earnings multiples; the projected efficiency differences between the existing health care facility and the new health care facility; and the historic value of

any tax exemptions granted to the existing health care facility.

(25) Whether the proposed conversion appropriately provides for the disposition of proceeds of the conversion which may include, but not be limited to the following:

(A) Whether an existing entity or a new entity will receive the proceeds.

(B) Whether appropriate tax status implications of the entity receiving the proceeds have been considered.

(C) Whether the mission statement and program agenda will be or should be closely related with the purpose of the mission of the existing health care facility.

(D) Whether any conflicts of interest arise in the proposed handling of the conversion proceeds.

(E) Whether the bylaws and articles of incorporation have been prepared for the new entity.

(F) Whether the board of any new or continuing entity will be independent from the new health care facility.

(G) Whether the method for selecting board members, staff, and consultants is appropriate.

(H) Whether the board will comprise an appropriate number of individuals with experience in pertinent areas such as foundations, health care, business, labor, community programs, financial management, legal, accounting, grant making, and public members representing diverse ethnic populations of the affected community.

(I) Whether the size of the board and proposed length of board members' terms are sufficient.

(26) Whether the transacting parties are in

compliance with the Charitable Trust Act.

(27) Whether a right of first refusal to repurchase the assets has been retained.

(28) Whether the character, commitment, competence, and standing in the community or other communities served by the transacting parties are satisfactory.

(29) Whether a control premium is an appropriate component of the proposed conversion.

(30) Whether the value of the assets factored in the conversion is based on past performance or future potential performance.

(31) The expected impact the proposed action will have on the individual workforces of each affected health care facility.

(32) Whether the expected workforce impact has been discussed with the affected employees and, in the case of employees who are represented by a duly certified or recognized bargaining representative, whether the health care facility has met its legal obligations to negotiate regarding the impact with that bargaining representative.

(33) Whether a separate certification has been submitted from each member of the governing board and from the chief executive and operating and financial officers of the corporation that is a party to the proposed conversion, executed under oath:

(A) Stating whether that director, chief executive, or operating or financial officer of the corporation is then or may become, within the 3-year period following the completion of the transaction, a member or shareholder in or an officer, employee, agent, or consultant of, or will otherwise derive any compensation or benefits, directly or indirectly, from the acquiring entity or any related party in connection with or as a result of the

disposition.

(B) Disclosing any financial interest held by that individual or that individual's family or held by any business in which the individual or a member of the individual's family owns a financial interest in any financial transaction within the prior 24 months with any of the parties participating in the conversion.

(C) Stating that the market value of the health care facility's assets has not been manipulated to decrease or increase value.

(D) Stating that the terms of the transaction are fair and reasonable.

(E) Stating that the proceeds of the transaction will be used solely in a manner consistent with the charitable purposes of the not-for-profit corporation.

(F) Stating that the conversion will not adversely affect the availability or accessibility of health care services in the county or municipality in which the existing health care facility or facilities are located.

This certification requirement is not applicable, however, to any governing board member who votes to oppose the proposed conversion and has submitted a statement to that effect to the Illinois Health Facilities Planning Board and the Attorney General.

Section 30. Application review process; Health Facilities Planning Board.

(a) The Illinois Health Facilities Planning Board must review all proposed conversions involving a health care facility in which a not-for-profit corporation is the acquiror or acquiree as follows:

(1) Upon receipt of a determination by the Attorney General concerning a proposed conversion, the Board must, within 10 business days, publish notice of the application in a newspaper of general circulation in the State stating that an initial application for conversion has been submitted, the names of the parties to the transaction, the date by which a person may submit written comments to the Board, and the date, time, and location of a public hearing regarding the application for conversion.

(2) No later than 45 days after receipt of a determination by the Attorney General concerning the proposed conversion, the Board must hold at least one public hearing in the service area of the acquiree health care facility. The number of public hearings that the Board holds must be appropriate to the size of the community in the health care facility's service area and the nature and value of the conversion to ensure that the community affected by the conversion has a meaningful opportunity to participate in the public hearing process. Upon request, any person must be given an opportunity to submit into the hearing record written comments, documents, and other exhibits and to offer oral testimony. Each party to the conversion must have a representative in attendance at all public hearings convened by the Board under this Section.

(3) At least 21 days before the public hearing, the Board must provide written notice of the time and place of the hearing through publication in one or more newspapers of general circulation in the affected communities, to the board of supervisors of the county in which the facility is located, and to all those who requested notice of the transaction.

(4) The Board must establish and maintain a summary

of written and oral comments made in preparation for and at the public hearing, including all questions posed, and must require answers of the appropriate parties. The summary and answers must be filed in the office of the Board and in the public library of the public library system for the community served by the health care facility. A copy shall be made available upon request to the Board.

(5) As part of the public hearing process, the Board must solicit comments and input regarding the potential risks and benefits of the conversion on health access and services, as set forth in subsection (b) of this Section.

(6) The Board has the power to subpoena additional information or witnesses, require and administer oaths, and require sworn statements at any time before making a decision on an application.

(7) Within 20 days following the receipt of a written determination approving a proposed conversion by the Attorney General, the Board must advise the applicant in writing whether the initial application for conversion is complete and, if it is not, must specify the additional information required.

(8) The Board must, upon receipt of the information requested, notify the applicant in writing of the official date of completion of the initial application.

(9) The Board must approve, approve with conditions directly related to the proposed conversion, or disapprove the initial application for conversion within 90 days after the date the completed application for conversion was submitted.

(b) In reviewing an application for conversion under this Section, the Board must consider the following criteria:

(1) Whether the character, commitment, competence,

and standing in the community, or any other communities served by the proposed parties to the transaction, are satisfactory.

(2) Whether sufficient safeguards are included to ensure the affected community's continued access to affordable health care.

(3) Whether the parties to the transaction have provided clear and convincing evidence that the new health care facility will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.

(4) Whether procedures are in place to ensure that ownership interests will not be used as incentives for patient referrals to the health care facility by physicians and other employees of the health care facility.

(5) Whether the parties to the transaction have made a commitment to ensure the continuation of collective bargaining rights, if applicable, and retention of the workforce.

(6) Whether the parties to the transaction have appropriately accounted for employment needs at the health care facility and addressed workforce retraining needed as a consequence of any proposed restructuring.

(7) Whether the proposed conversion demonstrates that the public interest will be served, considering the essential medical services needed to provide safe and adequate treatment, appropriate access, and balanced health care delivery to the residents of the State.

(8) Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval for any previous conversion pursuant to an application submitted under this Act.

(9) Whether health care employee staffing levels

will be adversely affected, and what impact the staffing levels will have on the quality of care provided by the facility.

Section 35. Payment in lieu of taxes agreement. A conversion under this Act must require the not-for-profit corporation to have a payment in lieu of taxes agreement with each taxing body requiring the not-for-profit corporation to pay each taxing body, in each year after the effective date of the conversion, the sums of money that were paid as real estate taxes in the year immediately preceding the conversion by the for-profit entity that was acquired.

Section 40. Solely for-profit corporations; Health Facilities Planning Board. The Board shall review all proposed conversions involving for-profit corporations as acquirors and acquirees in accordance with the procedures and review criteria set forth in Section 30 of this Act.

Section 45. Reports; use of experts; costs. The Illinois Health Facilities Planning Board or the Attorney General may, in carrying out their responsibilities under this Act, engage experts or consultants including, but not limited to, actuaries, investment bankers, accountants, attorneys, and industry analysts. All copies of reports prepared by experts and consultants, and the costs associated therewith, shall be made available to the parties to the conversion and the public. All costs incurred under this Section shall be the responsibility of one or more of the parties to the conversion in an amount to be determined by the Attorney General or the Director as he or she deems appropriate. No application for a conversion made under this Act shall be considered complete unless an agreement has been executed with the Attorney General or the Director for the payment of

costs in accordance with this Section.

Section 50. Investigations; notice to attend; court order to appear; contempt.

(a) The Director or the Attorney General may conduct investigations in discharging the duties required under this Act. For purposes of any such investigation, the Director or the Attorney General may require any person, agent, trustee, fiduciary, consultant, institution, association, or corporation directly related to the proposed conversion to appear at the time and place designated by the Director or the Attorney General, and then and there under oath to produce for the use of the Director or the Attorney General, or both, all documents and other information relating directly to the proposed conversion that the Director or the Attorney General may require.

(b) Whenever the Director or the Attorney General deems it necessary to require the attendance of any person as provided in subsection (a) of this Section, the Director or the Attorney General shall issue a notice to appear setting forth the time and place when attendance is required and shall cause the notice to be delivered or sent by registered or certified mail to the person at least 14 days before the date stated in the notice for the appearance.

(c) If any person receiving notice pursuant to this Section fails to appear or fails to produce documents or information as requested, the Director or the Attorney General may issue a notice to show cause and may commence contempt proceedings in the circuit court of the county in which the person was requested to appear or produce documents or information. The court may order the person to comply with the request of the Director or the Attorney General. Any failure or refusal to comply with the order of the court may be punished by the exercise of the court's contempt powers.

Section 55. Gag rules prohibited. A health care facility may not refuse to contract with, or compensate for covered services, an otherwise eligible provider solely because that provider has in good faith communicated with one or more of his or her patients regarding the provisions, terms, or requirements for services of the health care provider's products as they relate to the needs of that provider's patients.

Section 60. Prior approval; closing or significant reduction of medical services.

(a) A health care facility emergency department or primary care service that has been in existence for at least one year and that significantly serves uninsured or underinsured individuals and families may not be eliminated or significantly reduced without the prior approval of the Director in accordance with this Section.

(b) Before eliminating or significantly reducing an emergency room department or primary care service that has been in existence for at least one year and that significantly serves uninsured or underinsured individuals and families, the health care facility must provide a written plan to the Director describing the impact of such a proposal on access to health care services for traditionally underserved populations, the delivery of those services to the affected community, and other licensed health care facilities and providers in the affected community or in the State.

(c) Notwithstanding any other provision of Illinois law, the Director has the sole authority to review all plans submitted under this Section and to issue a determination within 90 days, or the request shall be deemed to have been approved. If the Director deems it appropriate, the Director may issue a public notice and receive written public comment

for 60 days following the date of receipt of the proposal.

Section 65. Limits to acquisitions; community benefits requirements; filings prohibited.

(a) A for-profit corporation, or its subsidiaries or affiliates, that applies for and receives approval for a conversion of a health care facility in accordance with this Act may not be permitted to apply for approval for a conversion of a second health care facility in this State for a period of 3 years after the initial conversion is approved and implemented.

(b) Notwithstanding subsection (a) of this Section, a for-profit corporation, together with its subsidiaries and affiliates, may apply for and receive approval for a conversion of 2 affiliated health care facilities in this State provided that (i) one of the 2 health care facilities' licenses was issued before the effective date of this Act and (ii) that license involves a specialty rehabilitation hospital that has a maximum of 90 beds. A conversion undertaken under this subsection shall be considered one conversion for purposes of this Section.

(c) If a for-profit corporation applies to hold, own, or acquire an ownership or controlling interest greater than 20% in more than one health care facility one year after the approval and implementation of a prior license, all provisions of this Act must be met, and, in addition to the review process and criteria set forth herein, the Department has the sole authority to determine, in its sound discretion:

(1) Whether the for-profit corporation provided community benefits as required or promised in connection with obtaining and holding a license or interest therein during the previous license period.

(2) Whether all terms and conditions of the prior license have been met.

(3) Whether all federal, State, and local laws, ordinances, and regulations have been complied with relative to any prior license.

(4) Whether the for-profit corporation planned, implemented, monitored, and reviewed a community benefit program during the prior license period.

(5) Whether the for-profit corporation provided an appropriate amount of charity care necessary to maintain or enhance a safe and accessible health care delivery system in the affected community and the State.

(6) Whether the for-profit corporation maintained, enhanced, or disrupted the essential medical services in the affected community and the State.

(7) Whether the for-profit corporation demonstrated a substantial linkage between the health care facility and the affected community by providing one or more of the following benefits: uncompensated care, charity care, cash or in-kind donations to community programs, education and training of professionals in community health issues, relevant research initiatives, or essential but unprofitable medical services if needed in the affected community.

(d) The Director may hold a public hearing to solicit input to assess the performance of a for-profit corporation or its affiliates or subsidiaries in providing community benefits in the affected community or the State.

(e) The Director has the sole authority to deny a for-profit corporation, or its affiliates, subsidiaries, or successors, permission to hold one or more than one license and, for good cause, may prohibit a for-profit corporation or its affiliates, subsidiaries, or successors from filing an application pursuant to this Act for a period not to exceed 10 years.

Section 70. Licensing fees. Nothing contained in this Act shall be deemed to affect any licensing fees set forth in the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act.

Section 75. No derogation of the Attorney General.

(a) No provision of this Act shall derogate from or limit the common law or statutory authority of the Attorney General, including the authority to investigate at any time charitable trusts for the purpose of determining and ascertaining whether they are being administered in accordance with law and the terms and purposes thereof.

(b) No provision of this Act shall be construed as a limitation on the application of the doctrine of cy pres or any other legal doctrine applicable to charitable assets or charitable trusts.

Section 80. Distribution of proceeds from acquisition; independent foundation.

(a) In the event of the approval of a conversion involving a not-for-profit corporation and a for-profit corporation that results in a new entity as provided in subdivision (b)(25)(A) of Section 25, it shall be required that the proceeds from the sale and any endowments and restricted, unrestricted, and specific-purpose funds be transferred to a charitable foundation operated by a board of directors (hereinafter referred to as "the foundation board").

(b) The Governor shall appoint the initial foundation board and shall approve, modify, or reject proposed by-laws or articles of incorporation provided by the parties to the transaction or the initial foundation board.

(c) The foundation board shall consist of no fewer than 7 and no more than 11 members and the Executive Director of

the foundation, who shall serve ex-officio. The foundation board may include one or more members with experience in matters of finance, law, business, labor, investments, community purpose, charitable giving, and health care, and shall be representative of the diversity of the population of the affected community. Not more than 3 members of the foundation board may be prior board members of the existing health care facility.

(d) The terms of foundation board members shall be 4 years, but the initial terms shall be 2, 3, and 4 years, as determined by lot, so that the terms are staggered. Foundation board members shall be limited to serving 2 full terms. The foundation board shall elect a chairperson from among its members, and other officers it deems necessary. The foundation board members shall serve without compensation.

(e) Control of the distribution of the proceeds of the funds is vested solely in the foundation board.

(f) Vacancies occurring on the foundation board shall be filled by a majority vote of the remaining board members.

Section 85. Powers and duties of the board. The foundation board is vested with full power, authority, and jurisdiction over the foundation and may perform all acts necessary or convenient in the exercise of any power, authority, or jurisdiction over the foundation.

Section 90. Immunity of board members, officers, and employees. Members of the foundation board and officers and employees of the foundation are immune from personal liability, either jointly or severally, for any debt or obligation created or incurred by the foundation unless their conduct is deemed to be gross negligence or wanton, willful, or reckless.

Section 95. Implementation.

(a) The Governor may take all steps necessary to effectuate the purposes of this Act, and the foundation board must be appointed no more than 60 days after the completion of the conversion. The board must act promptly to appoint an executive director, hire the staff deemed necessary, and acquire necessary facilities and supplies to begin the operation of the foundation.

(b) The foundation board must conduct a public hearing to solicit comments on the proposed mission statement, program agenda, corporate structure and strategic planning. The foundation board must hold a public hearing within 180 days after establishment of the board and on an annual basis thereafter.

Section 100. Annual report. The foundation board must submit an annual report and a copy of Internal Revenue Service form 990 to the Governor, the Attorney General, and the General Assembly.

Section 105. General powers and limitations. For the purpose of exercising the specific powers granted in this chapter and effectuating the other purposes of this Act, the foundation may do all of the following:

(1) Sue and be sued.

(2) Have a corporate seal and alter it at will.

(3) Make, amend, and repeal rules relating to the conduct of the business of the foundation.

(4) Enter into contracts relating to the administration of the foundation.

(5) Rent, lease, buy, or sell property in its own name, and construct or repair buildings necessary to provide space for its operations.

(6) Hire personnel, consultants, and experts and

set salaries.

(7) Perform all other functions and exercise all other powers that are necessary, appropriate, or convenient to administer the foundation.

Section 110. Whistleblower protections.

(a) A person subject to the provisions of this Act may not discharge, demote, threaten, or otherwise discriminate against any person or employee with respect to compensation, terms, conditions, or privileges of employment as a reprisal because the person or employer (or any person acting pursuant to the request of the employee) provided or attempted to provide information to the Director or his or her designee or to the Attorney General or his or her designee regarding possible violations of this Act.

(b) Any person or employee or former employee subject to the provisions of this Act who believes that he or she has been discharged or discriminated against in violation of subsection (a) of this Section may file a civil action within 3 years after the date of the discharge or discrimination.

(c) If a court of competent jurisdiction finds by a preponderance of the evidence that a violation of this Section has occurred, the court may grant the relief it deems appropriate, including the following:

(1) Reinstatement of the employee to the employee's former position.

(2) Compensatory damages, costs, and reasonable attorneys fees.

(3) Other relief to remedy past discrimination.

(d) The protections of this Section do not apply to any employee or person who:

(1) deliberately causes or participates in the alleged violation of the law or a regulation; or

(2) knowingly or recklessly provides substantially

false information to the Director or his or her designee or to the Attorney General or his or her designee.

Section 115. Failure to comply; penalties. If any person knowingly violates or fails to comply with any provision of this Act or willingly or knowingly gives false or incorrect information, the Director or the Attorney General may, after notice and an opportunity for a fair and prompt hearing, deny, suspend, or revoke a license or, instead of suspension or revocation of a license, may order the licensee to admit no additional persons to the health care facility, to provide health services to no additional persons through the health care facility, or to take corrective action necessary to secure compliance under this Act. Nothing in this Section shall be construed as precluding the prosecution of any person who violates this Act under applicable State, county, or municipal statutes, laws, or ordinances.

Section 120. Powers of the Department. The Department may adopt rules consistent with this Act, including measurable standards, as necessary to accomplish the purposes of this Act.

Section 125. Powers of the Attorney General. The Attorney General has the power to decide whether any information required by this Act is confidential or proprietary under subsection (g) of Section 7 of the Freedom of Information Act. Those determinations shall be made before any public notice of an initial application or any public availability of the information.

Section 135. Community benefits; basic requirements.

(a) Every health care facility that receives a license from this State must provide community benefits to the

community or communities it serves.

(b) Within 18 months after the effective date of this Act, every health care facility must develop, in collaboration with the community:

(1) An organizational mission statement that identifies the facility's commitment to developing, adopting, and implementing a community benefits program.

(2) A description of the process for approval of the mission statement by the health care facility's governing board.

(3) A declaration that senior management of the health care facility will be responsible for oversight and implementation of the community benefits plan.

(4) A community health assessment that evaluates the health needs and resources of the community served by the facility.

(5) A community benefits plan designed to achieve the following outcomes:

(A) Increase access to health care for members of the target community or communities.

(B) Address critical health care needs of members of the target community or communities.

(C) Foster measurable improvements in health for members of the target community or communities.

Section 140. Community health assessment

(a) Before adopting a community benefits plan, every health care facility subject to this Act must identify and prioritize the health needs of the community it serves. The facility also must identify health resources within the community. As part of the assessment, the health care facility must solicit comment from and meet with community groups, local government officials, health related organizations, and health care providers, with particular

attention given to those persons who are themselves underserved and those who work with underserved populations.

(b) The Department shall compile available public health data, including statistics on the State's unmet health care needs. In preparing its community health assessment, a health care facility must use available public health data.

(c) Health care facilities are encouraged to collaborate with other health care institutions in conducting community health assessments and may make use of existing studies and plans in completing their own community health assessments.

(d) Before finalizing the community health assessment, the health care facility must make available to the public a copy of the community health assessment for review and comment.

(e) Once finalized, the community health assessment must be updated at least every 3 years.

Section 145. Community benefits plan.

(a) Every health care facility must adopt, annually, a plan for providing community benefits.

(b) The community benefits plan must be drafted with input from the community.

(c) The community benefits plan must include, at a minimum:

(1) A list of the services the health care facility intends to provide in the following year to address community health needs identified in the community health assessment. Each listed service must be categorized as one of the following:

(A) Free care.

(B) Other services for vulnerable populations.

(C) Health research, education, and training programs.

(D) Community benefits that address public

health needs.

(E) Non-quantifiable services, such as local governance and preferential hiring policies that benefit those who are uninsured or underserved.

(2) A description of the target community or communities that the plan is intended to benefit.

(3) An estimate of the economic value of the community benefits that the health care facility intends to provide under the plan.

(4) A report summarizing the process used to elicit community participation in the community health assessment and community benefits plan design, and ongoing implementation and oversight.

(5) A list of individuals, organizations, and government officials consulted during development of the plan and a description of any provisions made for the promotion of ongoing participation by community members in the implementation of the plan.

(6) A statement identifying the health care needs of the communities that were considered in developing the plan.

(7) A statement describing the intended impact on health outcomes attributable to the plan, including short and long-term measurable goals and objectives.

(8) Mechanisms to evaluate the plan's effectiveness, including a method for soliciting comments by community members.

(9) The name and title of the person who is responsible for implementing the community benefits plan.

(d) Every health care facility must submit its community benefits plan to the Department before implementing the plan.

(e) Every health care facility must make its community benefits plan available to the public for review and comment before implementation.

(f) Every insurer must submit its community benefits plan to the Administration before implementing the plan.

(g) Every insurer must make its community benefits plan available to the public for review and comment before implementation.

Section 150. Annual report.

(a) Within 120 days after the end of a health care facility's fiscal year, the health care facility must submit to the Department an annual report detailing its community benefits efforts in the preceding calendar year. The annual report must include the following:

(1) The health care facility's mission statement.

(2) The amounts and types of community benefits provided, on a form to be developed by the Department.

(3) A statement of the health care facility's impact on health outcomes attributable to the plan, including a description of the health care facility's progress toward meeting its short-term and long-term goals and objectives.

(4) An evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited.

(5) The health care facility's audited financial statement.

(b) Every health care facility must prepare a statement announcing that its annual community benefits report is available to the public. The statement must be posted in prominent locations throughout the health care facility's premises, including the emergency room waiting area, the admissions waiting area, and the business office. The statement must also be included in any written material that discusses the admissions or free care criteria of the health care facility. A copy of the report must be given free of

charge to anyone who requests it. Information provided must be calculated in accordance with generally accepted accounting standards. This information must be calculated for each individual health care facility within a system and not on an aggregate basis, though both calculations may be submitted. Every health care facility must also file a calculation of its cost-to-charge ratio with its annual report.

(c) Any person who disagrees with a community benefits report may file a dissenting report with the Department. Dissenting reports must be filed within 60 days after the filing of the community benefits report, and shall become public records.

Section 155. Free care. Every health care facility that provides free care in full or partial fulfillment of its community benefits obligation must develop a written notice describing its free care program and explaining how to apply for free care. The notice must be in appropriate languages and conspicuously posted throughout the health care facility's premises, including the general waiting area, the emergency room waiting area, and the business office. Every health care facility that provides free care in full or partial fulfillment of its community benefits obligation must report the value of that care, provided that the value of the care may not include any bad debt costs.

Section 160. Subsidized care; sliding scale fees. In determining sliding scale fees or other payment schedules for uninsured persons, a health care facility must base those fees on the income of the uninsured person. If the sliding scale fee is below actual costs, the health care facility may include the difference in its community benefits computation.

Section 165. Monitoring and enforcement of community benefits.

(a) The Department shall assess a civil penalty of not less than $1,000 per day, for each day that the plan or report is not filed as required, against a health care facility that fails to file a community benefits plan or a timely annual community benefits report.

(b) The Department shall revoke or decline to renew the license of a health care facility that fails to provide community benefits as required by this Act. The Department may issue a provisional license for a period of up to one year to a health care facility that has had its license revoked or not renewed.

(c) Before taking any punitive action under this Section, the Department must hold an adjudicative hearing, giving the affected parties at least 14 days notice. Any person who filed a dissenting report to the facility's community benefits report has standing to testify at the hearing.

(d) Any punitive measure taken by the Department following the hearing shall be considered a final action for purposes of appeal. Any final action by the Department shall be subject to judicial review under the Administrative Review Law.

(e) The Attorney General may bring a civil action to enforce the collection of any monetary penalty imposed under this Section.

Section 170. Department report to General Assembly. The Department shall submit a report to the General Assembly on September 1 of each year that contains the following:

(1) The name of each health care facility, if any, that did not file a community benefits report in the preceding year.

(2) The name of each person who filed a dissenting report to a health care facility's community benefits report, and the substance of the complaint.

(3) A list of the most common activities performed by health care facilities in fulfillment of their community benefits obligations.

(4) The dollar value of the community benefits activities performed by health care facilities, expressed in both aggregate and individual terms.

(5) The amount of net patient revenue for each health care facility.

The Department's report must be made available to the public.

Section 200. Definitions. In the Sections following this Section and preceding Section 300:

"Right of first refusal" means that no other person may be hired before making the position available, through public notice of the availability, for a minimum of 30 days, to qualified displaced employees.

"Vacancy" means an available position that the hiring employer does not fill by promoting, transferring, or recalling a permanent employee. A position that is filled by a permanent employee who is on temporary leave status and expected to return to the position shall not be deemed a vacancy. An available position that requires the occupant to be a Board-certified physician shall not be deemed a vacancy.

Section 205. Filling of employee vacancies.

(a) Qualified applicants displaced by the hiring employer or an affiliated enterprise of the employer have priority to fill a vacancy over qualified applicants displaced by other health care facilities.

(b) When considering applications from more than one

qualified displaced employee applicant having equal priority to fill a vacancy, the hiring employer has discretion as to which employee will be offered employment. A position may be filled with an employee entitled to preference under Sections 200 through 215 at any time after the required notice of position availability is made.

(c) Nothing in Sections 200 through 215 shall preclude a hiring employer from establishing reasonable employment qualifications or prerequisites for a vacancy, provided that employees who performed essentially the same work before their displacement shall be deemed presumptively qualified for any comparable positions.

(d) A hiring employer may not discriminate against prospective employees on the basis of any seniority, recall, or employment rights protected under Sections 200 through 215.

(e) Employees who have been hired by the displacing employer or an affiliated enterprise, contractor, or successor of that employer pursuant to the preference rights under this Section may not be terminated during their first 3 months of employment except for just cause. Employees hired by any other health care facility pursuant to the preference rights under Sections 200 through 215 may be required to serve a 30-day probationary period by the new employer.

(f) An employer may not permanently fill a vacancy that would otherwise be available to an employee entitled to preference under Sections 200 through 215 by promoting or reassigning a temporary employee unless the temporary employee is also entitled to equal preference under Sections 200 through 215. An employer may fill a vacancy on a temporary basis, defined as less than 60 days, with an individual who is not entitled to preference while considering preference applications for the vacancy.

(g) Any preference-eligible employee who is displaced,

other than for cause, retains rights of seniority and recall with the employer by whom the employee was displaced, regardless of whether the employee accepts a position with another employer.

(h) As used in this Section, public notice of a vacancy requires, at a minimum, that the hiring employer place a notice of the vacancy with the local State employment office.

Section 210. Notice of pending employment displacement.

(a) Any health care facility that employs at least 10 employees must provide those employees, and the designated bargaining representative of those employees, with timely notice of any termination or other employment displacement, other than discharge or termination for cause, affecting more than 20% of the workforce or 2 employees in any one department, or more than 20% of the workforce or 10 employees at the facility, occurring within the period beginning 6 months before and ending one year after a conversion covered by this Act.

(b) Timely notice of impending employment displacement requires:

(1) In the case of an employer that employs 100 or more employees, a minimum notice of 90 days.

(2) In the case of an employer that employs fewer than 100 employees, a minimum notice of 60 days.

In the case of employees covered by a collective bargaining agreement, timely notice shall be the greater of the notice required under this Act or the notice required under the collective bargaining agreement.

(c) During the notice period, affected employees are entitled to attend employment interviews without loss of pay, provided that reasonable notice is given to the employer.

(d) A health care facility that fails to timely provide the statutory notice required by this Section is subject to

civil liability in an action filed in the circuit court by or on behalf of an employee or former employee within 3 years after the date of displacement. Upon a finding of a violation, the court may award the relief it deems appropriate, including, at a minimum, liquidated damages in the amount of $100 per day for the period between the time that notice should have been received and the date of actual notice of displacement, and the attorney's fees and costs incurred in filing and maintaining the action.

Section 215. Preferential hiring rights for employees terminated or displaced by a health care facility.

(a) In the case of any action that would result in employee displacement, the health care facility by which the employees are employed must provide for the following fair and equitable arrangements to protect the interests of affected employees:

(1) A right of first refusal to fill available vacancies for which they qualify, with continued seniority for benefit eligibility, at current or subsequently opened facilities owned, managed, or operated by the existing health care facility or by the new health care facility; provided, that if a vacancy would require affected employees to travel more than one hour from their current employment site, reasonable moving expenses shall be paid by the health care facility by which they will become employed.

(2) If the employment loss results from the contracting-out of the work by the employer health care facility, the employer must ensure that the contractor is contractually obligated to grant affected employees the right of first refusal to jobs for which they are qualified.

(3) Not later than the date of displacement, the

employer health care facility must provide each affected employee with notice of employment rights available under Sections 200 through 215. The notice must include identification of the employer's contact representative who can verify the employee's preference status under this Act and a listing of the employer's affiliated enterprises, successors, and contractors with whom the employee has preference eligibility at the time of displacement.

(b) A new health care facility that is created as the result of a conversion must, with respect to the employees of the pre-existing health care entity, provide those employees the right to continued employment in the job positions they had before the merger or consolidation, with full recognition of accrued seniority with the prior health care facility employer for benefit purposes, unless the employer can establish that the positions are not presently available because of a bona fide reduction in force, in which case the employer must provide any employees who thereby are unable to continue in a position the notice and rights provided under subsection (a) and a right of first refusal to any vacancies that become available within 12 months thereafter and for which they are qualified.

(c) Every health care facility operating within this State must provide notice of available vacancies and a preferential right of first refusal to those vacancies to qualified health care employees displaced by other health care facilities. The obligation and preferential right of first refusal provided under this subsection is subordinate to those rights provided under subsections (a) and (b).

(d) Any employee hired pursuant to this Section retains previously established seniority for the purpose of determining benefit entitlement with the new employer.

(e) Any employee or former employee who has been

adversely affected by reason of a violation of this Section may bring an action for monetary and injunctive relief, including reinstatement, compensatory damages, attorney's fees, and costs of the action, in the circuit court within 3 years after the violation.

Section 220. Neutrality concerning union organizing. State funds appropriated to implement this Act may not be used to assist, promote, or deter union organizing.

Section 300. Rules. The Department shall adopt rules necessary to implement this Act.

Section 400. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 900. The Ambulatory Surgical Treatment Center Act is amended by adding Sections 10.5, 10.10, 10.15, 10.20, 10.25, and 10.30 as follows:

(210 ILCS 5/10.5 new)

Sec. 10.5. Facility staffing standards.

(a) Every ambulatory surgical treatment center must ensure that it is staffed in a manner to provide sufficient, appropriately qualified staff of each classification and in each department or unit within the facility to meet the individualized care needs of the patients in the facility and must meet the requirements set forth in this Section.

(b) Every ambulatory surgical treatment center must have in place and follow an approved staffing plan that ensures adequate and appropriate delivery of health care services to patients. The staffing plan must be expressed in the minimum number, skill mix, and classification of personnel needed in each department or unit, based on the census and the usual or

average cumulative acuity of the patients cared for directly or indirectly in each department or unit. The staffing plan must be developed with the active participation of the direct care nursing staff within each department or unit.

(c) In addition to the basic staffing plan requirements set forth in subsection (b), every ambulatory surgical treatment center must have and follow a staffing system that ensures adequate and appropriate care and that includes the following features:

(1) A patient acuity system that meets the following requirements:

(A) It identifies, for each department or unit, the range of patient acuity permissible within the department or unit.

(B) It documents, on an individual patient basis, the patient diagnosis, the severity of the patient's illness, the need for specialized equipment and technology, patient assessments, the nursing care plan, and the level of staffing, by classification, necessary, in addition to the basic minimum staff set forth in subsection (b), to meet the care plan.

(C) It is utilized with the active participation of direct care nursing staff within each department.

(D) It references staffing ratios set by professional organizations that set standards of practice for specialty areas.

(E) It is validated at least annually or whenever a change in the system is proposed so that it reliably measures individualized patient care needs and staffing requirements.

(2) Staffing levels in the plan must be based on the acuity system referenced in paragraph (1) and must

take into account other unit activity (discharges, transfers, and admissions) and administrative and support tasks that must be done by staff within each classification.

(3) Every staffing system must include a statement of minimum qualifications for each staff classification referenced in the staffing plan and staffing system.

(4) Use of supplemental staff must include a statement of minimum qualifications for each staff classification referenced in the staffing plan and staffing system.

(210 ILCS 5/10.10 new)

Sec. 10.10. Mandatory overtime and excessive-duty hours prohibited.

(a) In this Section:

"Declared state of emergency" means an officially designated state of emergency that has been declared by a federal, State, or local government official having authority to declare that the State, county, municipality, or locality is in a state of emergency. The term does not include a state of emergency that results from a labor dispute in the health care industry.

"Mandatory" or "mandate" means any request that, if refused or declined by a health care employee, may result in discharge, discipline, loss of promotion, or other adverse employment consequence.

"Off-duty" means that an individual has no restrictions placed on his or her whereabouts and is free of all restraint or duty on behalf of an ambulatory surgical treatment center.

"On-duty" means that an individual is required to be available and ready to perform services on request within or on behalf of an ambulatory surgical treatment center, and includes any rest periods or breaks during which the

individual's ability to leave the facility is restricted either expressly or by work-related circumstances beyond the individual's control.

(b) Notwithstanding any other provision of law to the contrary, and subject only to the exceptions included in this Section, an ambulatory surgical treatment center may not mandate or otherwise require, directly or indirectly, a health care employee to work or be in on-duty status in excess of any of the following:

(1) The scheduled work shift or duty period.

(2) 12 hours in a 24-hour period.

(3) 40 hours in a 7-consecutive-day period.

Nothing in this subsection is intended to prohibit a health care employee from voluntarily working overtime.

(c) No health care employee may work or be in on-duty status more than 16 hours in any 24-hour period. Any health care employee working 16 hours in any 24-hour period must have at least 8 consecutive hours off duty before being required to return to duty. No health care employee may be required to work or be on duty more than 7 consecutive days without at least one consecutive 24-hour period off duty within that time.

(d) Notwithstanding any other provision of this Section, during a declared state of emergency in which an ambulatory surgical treatment center is requested, or otherwise reasonably may be expected, to provide an exceptional level of emergency or other medical services to the community, the mandatory-overtime prohibition under subsection (b) is inoperative to the following extent:

(1) Health care employees may be required to work or be on duty up to the maximum hour limitations set forth in subsection (b), provided that the ambulatory surgical treatment center has taken the steps set forth in subsection (e).

(2) Before requiring any health care employee to work mandatory overtime, the ambulatory surgical treatment center must make reasonable efforts to fill its immediate staffing needs through alternative efforts, including requesting off-duty staff to voluntarily report to work, requesting on-duty staff to volunteer for overtime hours, and recruiting per diem and registry staff to report to work.

(3) The exemption provided by this subsection may not exceed the duration of the declared state of emergency or the ambulatory surgical treatment center's direct role in responding to medical needs resulting from the declared state of emergency, whichever is less.

(e) During a declared state of emergency in which an ambulatory surgical treatment center is requested, or otherwise reasonably may be expected, to provide an exceptional level of emergency or other medical services to the community, the maximum hours limitation under subsection (c) is inoperative to the following extent:

(1) A health care employee may work or remain on duty for more than the maximum hour limitations set forth in subsection (c) under the following circumstances:

(A) The decision to work the additional time is voluntarily made by the individual health care employee affected.

(B) The health care employee is given at least one uninterrupted 4-hour rest period before the completion of the first 16 hours of duty and an uninterrupted 8-hour rest period at the completion of 24 hours of duty.

(C) No health care employee may work or remain on duty for more than 28 consecutive hours in a 72-hour period.

(D) A health care employee who has been on

duty for more than 16 hours in a 24-hour period who informs the health care facility that he or she needs immediate rest must be relieved from duty as soon thereafter as possible, consistent with patient safety needs, and must be given at least 8 uninterrupted hours off duty before being required to return for duty.

As used in this paragraph (1), "rest period" means a period in which an individual may be required to remain on the premises of the ambulatory surgical treatment center but is free of all restraint or duty or responsibility for work or duty should the occasion arise.

(2) The exemption provided by this subsection may not exceed the duration of the declared state of emergency or the ambulatory surgical treatment center's direct role in responding to medical needs resulting from the declared state of emergency, whichever is less.

(f) A work shift schedule or overtime program established pursuant to a collective bargaining agreement negotiated on behalf of the health care employees by a bona fide labor organization may provide for mandatory on-duty hours in excess of that permitted under subsection (b), provided that adequate measures are included in the agreement to ensure against excessive fatigue on the part of the affected employees.

(210 ILCS 5/10.15 new)

Sec. 10.15. Public disclosure.

(a) Every ambulatory surgical treatment center must maintain the following information:

(1) The staffing plan required under Section 10.5.

(2) Records that reflect daily staffing levels for each department and unit covered by the staffing plan.

(3) Nurse-sensitive patient outcome information (for example, infection and readmission rates).

(4) Mandated and actual staffing levels.

(b) Information required to be maintained under paragraphs (1), (2), and (4) of subsection (a) must be posted on each unit and in each department. All other information that must be maintained under this Section must be made available to the public upon request. The information must be provided within 14 days after the request.

(c) The ambulatory surgical treatment center must also post, and provide to the public upon request, a notice of violations of the staffing requirements set forth in Sections 10.5 through 10.15.

(210 ILCS 5/10.20 new)

Sec. 10.20. Employee's right to refuse assignment.

(a) An employee of an ambulatory surgical treatment center has a right to refuse assignment under conditions that would be in violation of the standards imposed by Sections 10.5 through 10.15 under the following circumstances:

(1) Education and experience have not prepared the employee to safely fulfill the assignment.

(2) The employee is required to work overtime, and the employee determines that the resulting level of fatigue or decreased alertness, or both, would compromise or jeopardize patient safety or the employee's ability to meet patient needs.

(3) The assignment does not meet staffing requirements, and the employee has the good-faith belief that patient care will be threatened by the proposed staffing.

(b) An employee may exercise his or her right to refuse an assignment under subsection (a) through the following procedure:

(1) The employee must first report his or her concern to his or her supervisor and ask to be relieved of the assignment.

(2) The supervisor must review the conditions, and either remedy situation causing the violation of standards, relieve the employee of the assignment, or advise the employee that he or she finds that the conditions do not justify relieving the employee.

(3) If the supervisor does not agree to relieve the employee of the assignment or remedy the alleged violation, the employee may exercise his or her right to refuse the assignment if:

(A) the supervisor rejects the request without proposing a remedy, or the proposed remedy is inadequate or untimely;

(B) the alleged violation cannot be timely addressed through the other enforcement provisions of Sections 10.5 through 10.15; and

(C) the employee in good faith believes that the assignment violates Sections 10.5 through 10.15 and would create an unsafe condition for either the employee or for patients who would be receiving care or services from the employee.

(4) An employee has a private cause of action for any violation of the rights set forth in this Section.

(210 ILCS 5/10.25 new)

Sec. 10.25. Enforcement.

(a) The Department must conduct unannounced, random site visits of ambulatory surgical treatment centers to determine compliance with the requirements of Sections 10.5 through 10.20. The ambulatory surgical treatment centers visited must be randomly selected, and every ambulatory surgical treatment center must be visited at least once within 6

months.

(b) The Department must also inspect an ambulatory surgical treatment center in response to a reported violation of Sections 10.5 through 10.20. These inspections must take place within 14 days after the Department receives a report of a violation. Every report of a violation must be investigated, whether it was written or oral.

(c) A violation may be reported by any person, including any employee. The identity of the person reporting the violation must remain confidential, and may not be disclosed to the ambulatory surgical treatment center.

(d) If the Department finds a violation of Sections 10.5 through 10.20 during either a random visit or an inspection resulting from a report of a violation, the Department must detail its finding in a written report and must prepare a correction plan. The Department shall conduct further investigations as necessary to determine compliance with the correction plan. Copies of both the finding of a violation and the correction plan must be made available to the public upon request.

(210 ILCS 5/10.30 new)

Sec. 10.30. Penalties for violations.

(a) An ambulatory surgical treatment center that is found to be in violation of any provision in Sections 10.5 through 10.20 is subject to any one or more of the following penalties:

(1) Loss of licensure under this Act.

(2) A civil penalty of not more than $5,000 per day for each day of a violation.

(3) Issuance of an order by a court of competent jurisdiction to correct the violation.

(b) If the health of patients is threatened by the violation, the Department may issue an order: to immediately

close the affected department or unit; to close the affected unit or department, or the entire facility, to further admissions; or imposing a regulatory overseer for the facility, department, or unit, with the overseer having the authority to assign additional staff at the cost of the facility.

(c) If the Department finds that a violation was willful or that there have been repeated violations by an ambulatory surgical treatment center, the Department may impose a civil penalty, as provided in subsection (a), against the chief executive officer of the facility or the chief nursing officer of the facility, or both.

(d) The Department may impose a civil penalty under this Section only after notice and a hearing at which the ambulatory surgical treatment center is given an opportunity to present evidence concerning the alleged violation.

(e) The Attorney General may bring a civil action to enforce the collection of a civil penalty imposed under this Section.

Section 905. The Hospital Licensing Act is amended by adding Sections 6.50, 6.55, 6.60, 6.65, 6.70, and 6.75 as follows:

(210 ILCS 85/6.50 new)

Sec. 6.50. Facility staffing standards.

(a) Every hospital must ensure that it is staffed in a manner to provide sufficient, appropriately qualified staff of each classification and in each department or unit within the facility to meet the individualized care needs of the patients in the facility and must meet the requirements set forth in this Section.

(b) Every hospital must have in place and follow an approved staffing plan that ensures adequate and appropriate

delivery of health care services to patients. The staffing plan must be expressed in the minimum number, skill mix, and classification of personnel needed in each department or unit, based on the census and the usual or average cumulative acuity of the patients cared for directly or indirectly in each department or unit. The staffing plan must be developed with the active participation of the direct care nursing staff within each department or unit.

(c) In addition to the basic staffing plan requirements set forth in subsection (b), every hospital must have and follow a staffing system that ensures adequate and appropriate care and that includes the following features:

(1) A patient acuity system that meets the following requirements:

(A) It identifies, for each department or unit, the range of patient acuity permissible within the department or unit.

(B) It documents, on an individual patient basis, the patient diagnosis, the severity of the patient's illness, the need for specialized equipment and technology, patient assessments, the nursing care plan, and the level of staffing, by classification, necessary, in addition to the basic minimum staff set forth in subsection (b), to meet the care plan.

(C) It is utilized with the active participation of direct care nursing staff within each department.

(D) It references staffing ratios set by professional organizations that set standards of practice for specialty areas.

(E) It is validated at least annually or whenever a change in the system is proposed so that it reliably measures individualized patient care

needs and staffing requirements.

(2) Staffing levels in the plan must be based on the acuity system referenced in paragraph (1) and must take into account other unit activity (discharges, transfers, and admissions) and administrative and support tasks that must be done by staff within each classification.

(3) Every staffing system must include a statement of minimum qualifications for each staff classification referenced in the staffing plan and staffing system.

(4) Use of supplemental staff must include a statement of minimum qualifications for each staff classification referenced in the staffing plan and staffing system.

(210 ILCS 85/6.55 new)

Sec. 6.55. Mandatory overtime and excessive-duty hours prohibited.

(a) In this Section:

"Declared state of emergency" means an officially designated state of emergency that has been declared by a federal, State, or local government official having authority to declare that the State, county, municipality, or locality is in a state of emergency. The term does not include a state of emergency that results from a labor dispute in the health care industry.

"Mandatory" or "mandate" means any request that, if refused or declined by a health care employee, may result in discharge, discipline, loss of promotion, or other adverse employment consequence.

"Off-duty" means that an individual has no restrictions placed on his or her whereabouts and is free of all restraint or duty on behalf of a hospital.

"On-duty" means that an individual is required to be

available and ready to perform services on request within or on behalf of a hospital, and includes any rest periods or breaks during which the individual's ability to leave the facility is restricted either expressly or by work-related circumstances beyond the individual's control.

(b) Notwithstanding any other provision of law to the contrary, and subject only to the exceptions included in this Section, a hospital may not mandate or otherwise require, directly or indirectly, a health care employee to work or be in on-duty status in excess of any of the following:

(1) The scheduled work shift or duty period.

(2) 12 hours in a 24-hour period.

(3) 40 hours in a 7-consecutive-day period.

Nothing in this subsection is intended to prohibit a health care employee from voluntarily working overtime.

(c) No health care employee may work or be in on-duty status more than 16 hours in any 24-hour period. Any health care employee working 16 hours in any 24-hour period must have at least 8 consecutive hours off duty before being required to return to duty. No health care employee may be required to work or be on duty more than 7 consecutive days without at least one consecutive 24-hour period off duty within that time.

(d) Notwithstanding any other provision of this Section, during a declared state of emergency in which a hospital is requested, or otherwise reasonably may be expected, to provide an exceptional level of emergency or other medical services to the community, the mandatory-overtime prohibition under subsection (b) is inoperative to the following extent:

(1) Health care employees may be required to work or be on duty up to the maximum hour limitations set forth in subsection (b), provided that the hospital has taken the steps set forth in subsection (e).

(2) Before requiring any health care employee to

work mandatory overtime, the hospital must make reasonable efforts to fill its immediate staffing needs through alternative efforts, including requesting off-duty staff to voluntarily report to work, requesting on-duty staff to volunteer for overtime hours, and recruiting per diem and registry staff to report to work.

(3) The exemption provided by this subsection may not exceed the duration of the declared state of emergency or the hospital's direct role in responding to medical needs resulting from the declared state of emergency, whichever is less.

(e) During a declared state of emergency in which hospital is requested, or otherwise reasonably may be expected, to provide an exceptional level of emergency or other medical services to the community, the maximum hours limitation under subsection (c) is inoperative to the following extent:

(1) A health care employee may work or remain on duty for more than the maximum hour limitations set forth in subsection (c) under the following circumstances:

(A) The decision to work the additional time is voluntarily made by the individual health care employee affected.

(B) The health care employee is given at least one uninterrupted 4-hour rest period before the completion of the first 16 hours of duty and an uninterrupted 8-hour rest period at the completion of 24 hours of duty.

(C) No health care employee may work or remain on duty for more than 28 consecutive hours in a 72-hour period.

(D) A health care employee who has been on duty for more than 16 hours in a 24-hour period who informs the health care facility that he or she

needs immediate rest must be relieved from duty as soon thereafter as possible, consistent with patient safety needs, and must be given at least 8 uninterrupted hours off duty before being required to return for duty.

As used in this paragraph (1), "rest period" means a period in which an individual may be required to remain on the premises of the hospital but is free of all restraint or duty or responsibility for work or duty should the occasion arise.

(2) The exemption provided by this subsection may not exceed the duration of the declared state of emergency or the hospital's direct role in responding to medical needs resulting from the declared state of emergency, whichever is less.

(f) A work shift schedule or overtime program established pursuant to a collective bargaining agreement negotiated on behalf of the health care employees by a bona fide labor organization may provide for mandatory on-duty hours in excess of that permitted under subsection (b), provided that adequate measures are included in the agreement to ensure against excessive fatigue on the part of the affected employees.

(210 ILCS 85/6.60 new)

Sec. 6.60. Public disclosure.

(a) Every hospital must maintain the following information:

(1) The staffing plan required under Section 6.50.

(2) Records that reflect daily staffing levels for each department and unit covered by the staffing plan.

(3) Nurse-sensitive patient outcome information (for example, infection and readmission rates).

(4) Mandated and actual staffing levels.

(b) Information required to be maintained under paragraphs (1), (2), and (4) of subsection (a) must be posted on each unit and in each department. All other information that must be maintained under this Section must be made available to the public upon request. The information must be provided within 14 days after the request.

(c) The hospital must also post, and provide to the public upon request, a notice of violations of the staffing requirements set forth in Sections 6.50 through 6.60.

(210 ILCS 85/6.65 new)

Sec. 6.65. Employee's right to refuse assignment.

(a) An employee of hospital has a right to refuse assignment under conditions that would be in violation of the standards imposed by Sections 6.50 through 6.60 under the following circumstances:

(1) Education and experience have not prepared the employee to safely fulfill the assignment.

(2) The employee is required to work overtime, and the employee determines that the resulting level of fatigue or decreased alertness, or both, would compromise or jeopardize patient safety or the employee's ability to meet patient needs.

(3) The assignment does not meet staffing requirements, and the employee has the good-faith belief that patient care will be threatened by the proposed staffing.

(b) An employee may exercise his or her right to refuse an assignment under subsection (a) through the following procedure:

(1) The employee must first report his or her concern to his or her supervisor and ask to be relieved of the assignment.

(2) The supervisor must review the conditions, and

either remedy situation causing the violation of standards, relieve the employee of the assignment, or advise the employee that he or she finds that the conditions do not justify relieving the employee.

(3) If the supervisor does not agree to relieve the employee of the assignment or remedy the alleged violation, the employee may exercise his or her right to refuse the assignment if:

(A) the supervisor rejects the request without proposing a remedy, or the proposed remedy is inadequate or untimely;

(B) the alleged violation cannot be timely addressed through the other enforcement provisions of Sections 6.50 through 6.60; and

(C) the employee in good faith believes that the assignment violates Sections 6.50 through 6.60 and would create an unsafe condition for either the employee or for patients who would be receiving care or services from the employee.

(4) An employee has a private cause of action for any violation of the rights set forth in this Section.

(210 ILCS 85/6.70 new)

Sec. 6.70. Enforcement.

(a) The Department must conduct unannounced, random site visits of hospitals to determine compliance with the requirements of Sections 6.50 through 6.65. The hospitals visited must be randomly selected, and every hospital must be visited at least once within 6 months.

(b) The Department must also inspect a hospital in response to a reported violation of Sections 6.50 through 6.65. These inspections must take place within 14 days after the Department receives a report of a violation. Every report of a violation must be investigated, whether it was

written or oral.

(c) A violation may be reported by any person, including any employee. The identity of the person reporting the violation must remain confidential, and may not be disclosed to the hospital.

(d) If the Department finds a violation of Sections 6.50 through 6.65 during either a random visit or an inspection resulting from a report of a violation, the Department must detail its finding in a written report and must prepare a correction plan. The Department shall conduct further investigations as necessary to determine compliance with the correction plan. Copies of both the finding of a violation and the correction plan must be made available to the public upon request.

(210 ILCS 85/6.75 new)

Sec. 6.75. Penalties for violations.

(a) A hospital that is found to be in violation of any provision in Sections 6.50 through 6.65 is subject to any one or more of the following penalties:

(1) Loss of licensure under this Act.

(2) A civil penalty of not more than $5,000 per day for each day of a violation.

(3) Issuance of an order by a court of competent jurisdiction to correct the violation.

(b) If the health of patients is threatened by the violation, the Department may issue an order: to immediately close the affected department or unit; to close the affected unit or department, or the entire facility, to further admissions or, in the case of an emergency room, to further patients; or imposing a regulatory overseer for the facility, department, or unit, with the overseer having the authority to assign additional staff at the cost of the facility.

(c) If the Department finds that a violation was willful

or that there have been repeated violations by a hospital, the Department may impose a civil penalty, as provided in subsection (a), against the chief executive officer of the facility or the chief nursing officer of the facility, or both.

(d) The Department may impose a civil penalty under this Section only after notice and a hearing at which the hospital is given an opportunity to present evidence concerning the alleged violation.

(e) The Attorney General may bring a civil action to enforce the collection of a civil penalty imposed under this Section.

Section 999. Effective date. This Act takes effect upon becoming law.