REPORT ON THE CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER DEMONSTRATION PROGRAM

PRESENTED PURSUANT TO
210 ILCS 3/
THE ALTERNATIVE HEALTH CARE DELIVERY ACT

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REPORT ON THE CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER DEMONSTRATION PROGRAM AS ESTABLISHED UNDER THE ALTERNATIVE HEALTH CARE DELIVERY ACT

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EXECUTIVE SUMMARY

This report is being submitted pursuant to *210 ILCS 3/, The Alternative Health Care Delivery Act*. The Act was intended to foster new and innovative solutions to the problems inherent in our State's health care delivery system by establishing demonstration models to license and study various alternative modes of health care delivery. To date, six categories of demonstration programs have been authorized under the Act.

The focus of this report is the children's community-based health care center demonstration model. The model was initially established under another name, the children's respite care center demonstration program. *PA 89-0393,* effective August 20, 1995, authorized up to eight children's respite care centers. After an initial period of operations, the demonstration model was altered by *PA 93-0402*. Effective January 1, 2004, participants in the program became known as children's community-based health care center models and began to offer transition care services in addition to respite care.

A children's community-based health care center is a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term respite stays and one to 120 day stays to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. The services authorized under this demonstration program are similar to home health care services or private duty nursing care provided in the home.

Since the authorization of the demonstration program in 1995, The Illinois Health Facilities Planning Board has received and approved two applications for a Certificate of Need (CON) to establish and operate a model under the demonstration program. At the time of this review, one of those facilities had completed the licensure process; the other CON is still pending licensure approval. The single licensed model was deemed in substantial compliance with the Act and the Code by the Department at each on-site review since commencing operation in 1999. However, this act has since been amended to no longer require a CON license (*PA 96-129*). Services at the model are to be provided in a home-like setting that serves no more than 12 children at a time. To date, there are four active facilities operating within the state; three are operated under one parent entity while the other operates with an extra six beds.

Medicaid was identified as the primary revenue stream for the model. Medicaid was identified as the largest earned revenue source for the model, followed by payments made by the Illinois Department of Healthcare and Family Services (DCFS) under the Home and Community-Based Services waiver designated in section 1915 (c) of the Social Security Act for medically fragile and technology dependent children.

THE ALTERNATIVE HEALTH CARE DELIVERY ACT

I. INTRODUCTION

The Alternative Health Care Delivery Act, 210 ILCS 3/ (P.A. 87-1188), enacted September 24, 1992, was intended to foster new and innovative solutions to the problems inherent in the State's health care delivery systems through the development of demonstration projects to license and study alternative health care delivery systems.

The purpose of the Alternative Health Care Delivery Act is stated as:

> "The General Assembly finds that many consumers have limited access to needed health care. Other consumers have limited health care choices. Consumers of health care also experience high out-of-pocket costs for health care and the State as a whole experiences high aggregate health care costs. The General Assembly also finds that the provision of high quality services, regardless of setting, for care is of overriding importance. Currently, there is insufficient data and information on the efficacy of alternative models of health care delivery. New and innovative solutions must be found to correct these problems. This Act is intended to foster those innovations through the development of demonstration projects to license and study alternative health care delivery systems. Furthermore, these demonstration projects shall be developed in an orderly manner and regulated by the Department of Public Health. Goals of the alternative delivery models are to increase access to needed health care, to expand the number of health care choices available to consumers, to lower consumer's out-of-pocket health care costs, and to lower aggregate health care costs in the State as a whole."

To date, six categories of alternative health care delivery demonstration programs have been authorized under the Act. A copy of the Act is appended to this report as **Appendix A**.

	DEMONSTRATION PROGRAM	EFFECTIVE	AMENDED
1	Subacute Care Hospital	9/24/1992	93-0402
2	Postsurgical Recovery Care Center	8/20/1993	91-65
3	Children's Respite Care Center/ Children's Community-Based Health Care Center (amend)	8/20/1995	93-0402
4	Alzheimer's Disease Management Center	6/16/2000	
5	Community-Based Residential Rehab. Center	7/9/1999	93-0402
6	Birth Center	8/27/2007	95-0445

II. BACKGROUND OF THE ACT

The Alternative Health Care Delivery Act outlines the process for the selection, implementation and evaluation of alternative health care delivery concepts and the responsibilities of the parties involved. The process begins with the State Board of Health investigating new health care delivery models and recommending to the Governor and the General Assembly, through the Department, those models that should be authorized as alternative health care models for which demonstration programs should be initiated under the Act.

A demonstration program is a program to license and study those alternative health care models authorized under the Act. The Board shall advise the Department on the definition and scope of alternative health care models. The Department is responsible for the formulation and adoption of rules for each alternative health care model authorized under the Act. The rules for the administration of the Children's Community-Based Health Care Center Model Demonstration Program are appended to this report as **Appendix B.**

The rules adopted by the Department further establish the definition and scope of the program. The rules set forth the license application information required by the Department, describe the care of patients of the alternative health care models, establish the rights afforded to patients of the alternative health care models, describe the physical plant requirements, establish license application and renewal fees, and contain information that may be necessary for the Board and the Department to monitor and evaluate the alternative health care model demonstration program.

Some alternative health care delivery model demonstration programs require applicants to obtain a Certificate-of-Need from the Illinois Health Facilities Planning Board (IHFPB) prior to being eligible for licensure. In those cases, the IHFPB develops rules related to the particular model as well as review criteria for the evaluation of applications for permit to participate in the demonstration program.

The State Board of Health is mandated by the Act to evaluate and make recommendations to the Governor and the General Assembly, through the Department, regarding the alternative health care model demonstration programs established under the Act.

The Board's evaluation shall include, but is not limited to, whether the alternative health care models improved access to health care for their service populations, the quality of care, the cost and cost effectiveness of the alternative health care models, the impact of the alternative health care models on the health care system in that area, the implementation of any special commitments made during application review by the Illinois Health Facilities Planning Board, and the continuation, expansion, or modification of alternative health care models.

The alternative health care model authorized under this demonstration program was initially established as a children's respite care center under *PA 89-0393*. This legislation authorized up to eight children's respite care center models and took effect August 20, 1995. The first facility to participate in the demonstration program received a license to operate a children's respite care center.

After an initial period of operation, legislation amending the children's respite care center model, *PA 93-0402*, was introduced and adopted. Effective January 1, 2004, models authorized under the demonstration program became known as children's community-based health care centers. The four facilities participating in the demonstration program as a children's respite care center model at that time now constitute as the children's community-based health care center model.

The Alternative Health Care Delivery Act defines a Children's Community-Based Health Care Center as:

> "a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term stays and 120 days to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. This care is to be provided in a home-like environment that serves no more than 12 children at a time. Children's community-based health care center services must be available through the model to all families, including those whose care is paid for through the Department of Public Aid, the Department of Children and Family Services, the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home. Each children's community-based health care center model location shall be physically separate and apart from any other facility licensed by the Department of Public Health under this or any other Act and shall provide the following services: respite care, registered nursing or licensed practical nursing care, transitional care to facilitate home placement or other appropriate settings and reunite families, medical day care, weekend camps, and diagnostic studies typically done in the home setting."

Under the original authorization of the demonstration program, patient stays were limited to a period of one to fourteen days. The service population was defined as children younger than 19 years of age. The amendatory legislation, *PA 93-0402*, modified the demonstration program to allow long-term patient stays for a period of one to 120 days to facilitate transitions to home or other appropriate settings of care. The service population is now defined as children younger than 22 years of age.

The Department developed rules providing further definition of the service population for a children's community-based health care center. These rules are contained in *77 Ill. Adm. Code 260.1000.* The service population is defined as children younger than 22 years of age who are:

i. Medically fragile….

"children who are medically stable but require skilled nursing care, specialized therapy, and specialized medical equipment and supplies to enhance or sustain their lives. 'Medically fragile children' may include, but is not limited to, children who have neuro-muscular disease, heart disease, cancer, seizure disorder, spina bifida, chronic lung disease, or other medical conditions that threaten the child's ability to thrive and to survive without proper medical care."

ii. Technology dependent…

"medically fragile children who require the constant or regular intermittent use of technology to meet their medical needs. This may include, but it is not limited to, devices that assist or support breathing, monitor bodily functions, or provide nutrition."

iii. Children with special health care needs…

"those children who have or are at an increased risk for chronic physical ailments who require health and related services of a type or amount beyond that required by children generally."

II. HISTORY

The Alternative Health Care Delivery Act sets forth both the number of children's community-based health care centers authorized and the geographic areas in which they are to be located. The Act authorizes eight models for the demonstration program.

The eight model locations are to be located as follows: 1 in the City of Chicago; 1 in Cook County outside the City of Chicago; 2 in the area comprised of DuPage, Kane, Lake, McHenry, and Will counties; 2 in municipalities with a population of 50,000 or more and not located in the areas described above; and 2 in rural areas, as defined by the Health Facilities Planning Board. No more than 1 children's community-based health care center model owned and operated by a licensed skilled pediatric facility shall be located in each of the designated areas.

The Act requires all children's community-based health care center model applicants to obtain a certificate of need from the Illinois Health Facilities Planning Board prior to licensure. On account of the very limited scope of the demonstration programs authorized by the Act, the Illinois Health Facilities Planning Board developed rules for the evaluation of applications for certificates of need for the establishment of models which are based on a competitive point system. The review criteria and point system for the Children's Respite Care Center Alternative Health Care Model are contained in Sections 1110.2730 and 1110.2640 of *Title 77 Illinois Administrative Code.*

Since the inception of the children's respite care center demonstration program on August 20, 1995, up until the completion of this review, the Illinois Health Facilities Planning Board has received four applications for certificate of need permits for the demonstration project. Since September 28th of 2018, there have been four operating facilities distributed throughout the state.

III. EVALUATION METHODOLOGY

To assist the Illinois State Board of Health in its mandated evaluation of the children's community-based health care center demonstration program, the Department conducted an in-depth review of all facilities licensed as model participants. Four seperate children's community-based health care centers were functioning and available for inclusion in the review.

To gather insight into the operation of the model and its impact on the health care system in its service area, the Department utilized several methods of data collection. Data collection efforts included: a review of licensure records and results of on site reviews, a request for input from other related organizations or interested parties, a survey of parents/guardians of children who have received care at the model, and a formal survey of the only model participating in the demonstration program.

i. REVIEW OF RECORDS AND RELATED STUDIES

The Department reviewed records relating to the Certificate of Need applications for the demonstration program and the applications for licensing under the program. Two facilities had applied for and been granted a CON to establish and operate a children's respite care center under the demonstration program.

ii. SURVEY OF DEMONSTRATION PROGRAM PARTICIPANTS

The Department created a formal survey instrument to collect information pertinent to the Board's evaluation of the model. The sole model was required to complete the survey tool.

For purposes of this review, the survey components were typically separated by program service and/or funding source. The accuracy of data collected through the survey is the responsibility of the facility's management and its designated representatives.

IV. SYNOPSIS

The following sections summarize many of the key features of the children's community-based health care center model, which were identified during the review. Due to the limited scope of the review, the following sections contain information which is based on a single model. This limited context should be considered in conjunction with the results and conclusions, and recommendations contained later in the report.

i. LOCATION AND SERVICE SETTING

The first community-based health care center model licensed in Illinois is located in DuPage County. The Act authorized one additional model to be located in this service area, which is comprised of DuPage, Kane, Lake, McHenry, and Will counties. A total of six additional models are authorized in other service areas across the State.

Currently, there are four children's community-based health care centers throughout the state. Three of these facilities are owned and operated by the *Almost Home Kids* not-for-profit; their locations are based in Naperville, Chicago (Streeterville) and Peoria. The fourth additional facility is located in Chicago (Portage Park) and operated by *Maryville Children's Healthcare Center*.

Each model facility is required under the Act to provide care in a home-like environment. Additional space is often made available for parents/guardians who are participating in training to facilitate a child's transition from the hospital to the home or another appropriate service setting.

Name	Location	License number	Date Licensed
The Center for Coordinating Action for Children's Health dba Almost Home Kids	7 S. 721 Route 53, Naperville, IL 60540	LIC: 4000020	11/23/1999
Maryville Academy Children's Healthcare Center	4015 N. Oak Park, Chicago, IL 60634	LIC: 4000022	4/9/2008
The Center for Coordinating Action for Children's Health dba Almost Home Kids	211 E Grand Ave, Chicago, IL 60611	LIC: 4000024	9/7/2012
The Center for Coordinating Action for Children's Health dba Almost Home Kids	5200 N Hamilton, Peoria, IL 61614	LIC: 4000030	9/28/2018

ii. PROGRAM SERVICES

All children's community-based health care center models must establish admission criteria for its program services in accordance with the Act and the Code. The model requires that any child under 22 years of age who has special health care needs that require some type of medical supervision ordered by a physician can use its services. Respite and transitional care programs require physician approval. Transition Care referrals are accepted from Hospital Discharge Planners, Social Workers, Nurses, and Physicians. All three of the *Almost Home Kids* facilities utilize the full twelve beds while *Maryville* has received a special permit from the Department to utilize sixteen beds. *Maryville* has been granted permission to expand to sixteen beds; the legislative change allows for one facility to expand per Public Act 100-518.

Respite care is a short term stay for a child who is medically fragile and/or who may be technology dependent. From daily/overnight stays up to 14 days total, the child is provided medical/nursing care and recreational activities in a secure and therapeutic environment, while their parents/caregivers tend to personal or family issues. Families may choose to use the model for respite care for a variety of circumstances: unfilled nursing shifts, parent/guardian illness or need for surgery, vacations, family emergencies or much needed sleep/rest.

When a child is eligible for discharge from a hospital and no longer in need of an acute level of care, the transition program is available for long term stays up to 120 days at the model. Families may choose to use the model for assistance between hospital and home due to changes in payer sources, nursing agencies, foster care and adoption, or simply for additional time needed to prepare the home environment for the child. Funding for this service is paid by State or private payer sources and approval must be received by a doctor prior to admission.

V. RESULTS & CONCLUSIONS

The health care needs and their associated expenses for the service population are considerable and also highly variable from one individual child to the next. Factors such as the child's degree of reliance on medical devices, the number of devices the child requires, or the amount and intensity of nursing care the child needs daily all impact the health care costs associated with the service population.

Expansions in Medicaid coverage and waiver programs in Illinois now allow many families access to a wide variety of services in the community, such as the children's community-based health care center model. The purpose of community-based support is to allow families to care for a medically complex child in the home, often preventing a long-term institutional placement. A home placement is typically regarded as more cost-effective means to providing for the long-term health care needs of the service population.

Under the Act, a children's community-based health care center model must make its services available to all families, including those whose care is paid for through the Department of Healthcare and Family Services, the Department of Children and Family Services (DCFS), the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home.

Data regarding bed care for DCFS children illustrate the model's positive impact for these children. *Table IIB* demonstrates the rising needs of these facilities, especially the urban facilities that serve Chicago. Furthermore, another rising use of children's community-based health care center's is the emergence of English as a second language for translation. Each facility lists that have translation services onsite and utilize them frequently (see *Table IIC)*.

Although not required by the Act, the operator of the model is recognized by the IRS as an organization exempt from federal income taxes under Section 501 (c)(3) of the Internal Revenue Code. As a recognized not-for-profit organization, the model expends a portion of its resources on fundraising activities each year in order to raise additional support for its operations. Under the Act, a children's community-based health care center model must provide charitable care consistent with that provided by comparable health care providers in the geographic area.

Audited financial statements for the model's past three fiscal years were submitted along with the survey. These statements, along with financial information provided by the model, appear to indicate that the revenues generated through program services tell contrasting but worthwhile stories. *Maryville* has slowly been increasing their yearly revenue, while *Almost Home Kids* has stayed consistent (See *Table IIIA*). In addition, services at the model are also supported through thousands of donated volunteer hours each year.

The model reported different utilization levels by facility. As *Almost Home Kids* expands, their utilization rates declined as they have more space and can coordinate between their two Chicagoland facilities. Per *Maryville*, their utilization rate shot up from 68.75% to ~87.5%; this is more problematic as their facility as it means they are busier, for more of the year.
Each survey that was returned to the Department also included a brief advantages/disadvantages table that outlined significant factors for each. Some of the disadvantage's facilities face revolve around geographical issues to access and specifically the *per diem cost of care* which causes the *Almost Home Kids* facilities to operate at a slight loss. Furthermore, smaller hurdles to clear consist of things like bed availability and medical reimbursements via Medicaid.

Conversely, facilities report that they're incredibly valuable to medically fragile children in providing the care they need and specifically assisting their adjustment home. children's community-based health care centers also are key in helping transitioning parents understand how to care for their children in a non-hospital/appropriate setting. Per *Almost Home Kids*, they play a crucial role in lowering hospital readmission rates and keeping children out of the ER. Lastly, *Maryville* notes that they provide a key role in being able to shift medically fragile children into foster care and school settings.

Another strong finding the Department has learned from *Table IB* is crucial to understanding how to streamline the model. While children's community-based health care centers must offer medical day care and weekend camps, none of the facilities have had virtually any luck utilizing this program. In fact, *Almost Home Kids* with the Department have discussed the possibility about removing the guideline from the statute, but there is no clear option moving forward.

The Department also finds interesting trends regarding emergent and non-emergent transfers to hospitals. Firstly, non-emergent transfers are simply planned transfers to assist a child's acute care needs, while emergency visits are not. According to *Table IC*, the Department has found that while non-emergent transfers have stayed consistent for all facilities within the previous three years. What's more compelling is observing the trends of both the *Almost Home Kids* and *Maryville* under their emergency transfers. *Almost Home Kids'* numbers have fluctuated throughout the last three calendar years while *Maryville* has steadily declined the number of emergency transfers to the hospital.

The last and perhaps most important metric that illustrates how successful these facilities are how the children exit the care. Clearly, one of the pillars of the entire notion of children's community-based health care centers is how they can assist parents in learning how to care for their child; it is incredibly important that transitional care transfers are successful. *Table IIB* shows that *Almost Home Kids* (*Chicago/Naperville*) has consistently stayed around 90% discharge to a family member/home while limiting skilled nursing releases. *Maryville* wasn't as successful in 2016 but have managed to improve over time. In the brief timeframe of *Almost Home Kids Peoria*, ¾ of their transitional patients have left to their Children's Hospital. In all, all four of these facilities are getting more successful by year, and there is no reason to believe these numbers will not stay consistent.

VI. RECOMMENDATIONS

At the time this review was initiated, the children's community-based health care center demonstration program was functioning at a considerably low level. Although 8 children's community-based health care center models are authorized under the Act and each may operate up to twelve beds, the demonstration program has consisted of a total of four facilities. All three of the *Almost Home Kids* facilities utilize the full twelve beds while *Maryville* has received a special permit from the Department to utilize sixteen beds.

The demonstration program should be reevaluated after a reasonable period of continued operation and monitoring per the statute – this author suggests a five-year period, more than enough time for any future. Provided that there are only four parties that have been participating in this pilot project, any additional expressed interest in the model or lack thereof should be monitored and reported upon further review of the children's community-based health care center demonstration program. The statute and administrative rules should be updated to reflect the current program.

While endorsing the program to continue, the Department will continue to monitor children's community-based health care centers. Given that no other models were available for direct comparison or to substantiate the findings of this review, the Department is reluctant to offer any concrete recommendations regarding the demonstration program at this time.

APPENDIX A:

THE ALTERNATIVE HEALTH CARE DELIVERY ACT

HEALTH FACILITIES
(210 ILCS 3/) Alternative Health Care Delivery Act.

(210 ILCS 3/1)

Sec. 1. Short title. This Act may be cited as the Alternative Health Care Delivery Act.
(Source: P.A. 87-1188.)

(210 ILCS 3/5)

Sec. 5. Purpose. The General Assembly finds that many consumers have limited access to needed health care. Other consumers have limited health care choices. Consumers of health care also experience high out-of-pocket costs for health care, and the State as a whole experiences high aggregate health care costs. The General Assembly also finds that the provision of high quality services, regardless of setting, for care is of overriding importance. Currently, there is insufficient data and information on the efficacy of alternative models of health care delivery. New and innovative solutions must be found to correct these problems. This Act is intended to foster those innovations through the development of demonstration projects to license and study alternative health care delivery systems. Furthermore, these demonstration projects shall be developed in an orderly manner and regulated by the Department of Public Health.
(Source: P.A. 87-1188.)

(210 ILCS 3/10)

Sec. 10. Definitions. In this Act, unless the context otherwise requires:

"Alternative health care model" means a facility or program authorized under Section 35 of this Act.

"Board" means the State Board of Health.

"Department" means the Illinois Department of Public Health.

"Demonstration program" means a program to license and study alternative health care models authorized under this Act.

"Director" means the Director of Public Health.
(Source: P.A. 87-1188.)

(210 ILCS 3/15)

Sec. 15. License required. No health care facility or

program that meets the definition and scope of an alternative health care model shall operate as such unless it is a participant in a demonstration program under this Act and licensed by the Department as an alternative health care model. The provisions of this Section as they relate to subacute care hospitals shall not apply to hospitals licensed under the Illinois Hospital Licensing Act or skilled nursing facilities licensed under the Illinois Nursing Home Care Act; provided, however, that the facilities shall not hold themselves out to the public as subacute care hospitals. The provisions of this Act concerning children's respite care centers shall not apply to any facility licensed under the Hospital Licensing Act, the Nursing Home Care Act, or the University of Illinois Hospital Act that provides respite care services to children.
(Source: P.A. 95-331, eff. 8-21-07.)

(210 ILCS 3/20)

Sec. 20. Board responsibilities. The State Board of Health shall have the responsibilities set forth in this Section.

(a) The Board shall investigate new health care delivery models and recommend to the Governor and the General Assembly, through the Department, those models that should be authorized as alternative health care models for which demonstration programs should be initiated. In its deliberations, the Board shall use the following criteria:

(1) The feasibility of operating the model in Illinois, based on a review of the experience in other states including the impact on health professionals of other health care programs or facilities.

(2) The potential of the model to meet an unmet need.

(3) The potential of the model to reduce health care costs to consumers, costs to third party payors, and aggregate costs to the public.

(4) The potential of the model to maintain or improve the standards of health care delivery in some measurable fashion.

(5) The potential of the model to provide increased choices or access for patients.

(b) The Board shall evaluate and make recommendations to the Governor and the General Assembly, through the Department, regarding alternative health care model demonstration programs established under this Act, at the midpoint and end of the period of operation of the demonstration programs. The report shall include, at a minimum, the following:

(1) Whether the alternative health care models improved access to health care for their service populations in the State.

(2) The quality of care provided by the alternative health care models as may be evidenced by health outcomes, surveillance reports, and administrative actions taken by the Department.

(3) The cost and cost effectiveness to the public,

third-party payors, and government of the alternative health care models, including the impact of pilot programs on aggregate health care costs in the area. In addition to any other information collected by the Board under this Section, the Board shall collect from postsurgical recovery care centers uniform billing data substantially the same as specified in Section 4-2(e) of the Illinois Health Finance Reform Act. To facilitate its evaluation of that data, the Board shall forward a copy of the data to the Illinois Health Care Cost Containment Council. All patient identifiers shall be removed from the data before it is submitted to the Board or Council.

(4) The impact of the alternative health care models on the health care system in that area, including changing patterns of patient demand and utilization, financial viability, and feasibility of operation of service in inpatient and alternative models in the area.

(5) The implementation by alternative health care models of any special commitments made during application review to the Illinois Health Facilities Planning Board.

(6) The continuation, expansion, or modification of the alternative health care models.

(c) The Board shall advise the Department on the definition and scope of alternative health care models demonstration programs.

(d) In carrying out its responsibilities under this Section, the Board shall seek the advice of other Department advisory boards or committees that may be impacted by the alternative health care model or the proposed model of health care delivery. The Board shall also seek input from other interested parties, which may include holding public hearings.

(e) The Board shall otherwise advise the Department on the administration of the Act as the Board deems appropriate.
(Source: P.A. 87-1188; 88-441.)

(210 ILCS 3/25)

Sec. 25. Department responsibilities. The Department shall have the responsibilities set forth in this Section.

(a) The Department shall adopt rules for each alternative health care model authorized under this Act that shall include but not be limited to the following:

(1) Further definition of the alternative health care models.

(2) The definition and scope of the demonstration program, including the implementation date and period of operation, not to exceed 5 years.

(3) License application information required by the Department.

(4) The care of patients in the alternative health care models.

(5) Rights afforded to patients of the alternative health care models.

(6) Physical plant requirements.

(7) License application and renewal fees, which may cover the cost of administering the demonstration program.

(8) Information that may be necessary for the Board and the Department to monitor and evaluate the alternative health care model demonstration program.

(9) Administrative fines that may be assessed by the Department for violations of this Act or the rules adopted under this Act.

(b) The Department shall issue, renew, deny, suspend, or revoke licenses for alternative health care models.

(c) The Department shall perform licensure inspections of alternative health care models as deemed necessary by the Department to ensure compliance with this Act or rules.

(d) The Department shall deposit application fees, renewal fees, and fines into the Regulatory Evaluation and Basic Enforcement Fund.

(e) The Department shall assist the Board in performing the Board's responsibilities under this Act.

(f) The Department shall conduct a study to determine the feasibility, the potential risks and benefits to patients, and the potential effect on the health care delivery system of authorizing recovery care of nonsurgical patients in postsurgical recovery center demonstration models. The Department shall report the findings of the study to the General Assembly no later than November 1, 1998. The Director shall appoint an advisory committee with representation from the Illinois Hospital and Health Systems Association, the Illinois State Medical Society, and the Illinois Freestanding Surgery Center Association, a physician who is board certified in internal medicine, a consumer, and other representatives deemed appropriate by the Director. The advisory committee shall advise the Department as it carries out the study.

(g) Before November 1, 1998 the Department shall initiate a process to request public comments on how postsurgical recovery centers admitting nonsurgical patients should be regulated.

(Source: P.A. 90-600, eff. 6-25-98; 90-655, eff. 7-30-98.)

(210 ILCS 3/30)

Sec. 30. Demonstration program requirements. The requirements set forth in this Section shall apply to demonstration programs.

(a) There shall be no more than:

(i) 3 subacute care hospital alternative health care models in the City of Chicago (one of which shall be located on a designated site and shall have been licensed as a hospital under the Illinois Hospital Licensing Act within the 10 years immediately before the application for a license);

(ii) 2 subacute care hospital alternative health care models in the demonstration program for each of the following areas:

(1) Cook County outside the City of Chicago.

(2) DuPage, Kane, Lake, McHenry, and Will Counties.

(3) Municipalities with a population greater than 50,000 not located in the areas described in item (i) of subsection (a) and paragraphs (1) and (2) of item (ii) of subsection (a); and

(iii) 4 subacute care hospital alternative health care models in the demonstration program for rural areas.

In selecting among applicants for these licenses in rural areas, the Health Facilities Planning Board and the Department shall give preference to hospitals that may be unable for economic reasons to provide continued service to the community in which they are located unless the hospital were to receive an alternative health care model license.

(a-5) There shall be no more than a total of 12 postsurgical recovery care center alternative health care models in the demonstration program, located as follows:

(1) Two in the City of Chicago.

(2) Two in Cook County outside the City of Chicago. At least one of these shall be owned or operated by a hospital devoted exclusively to caring for children.

(3) Two in Kane, Lake, and McHenry Counties.

(4) Four in municipalities with a population of 50,000 or more not located in the areas described in paragraphs (1), (2), and (3), 3 of which shall be owned or operated by hospitals, at least 2 of which shall be located in counties with a population of less than 175,000, according to the most recent decennial census for which data are available, and one of which shall be owned or operated by an ambulatory surgical treatment center.

(5) Two in rural areas, both of which shall be owned or operated by hospitals.

There shall be no postsurgical recovery care center alternative health care models located in counties with populations greater than 600,000 but less than 1,000,000. A proposed postsurgical recovery care center must be owned or operated by a hospital if it is to be located within, or will primarily serve the residents of, a health service area in which more than 60% of the gross patient revenue of the hospitals within that health service area are derived from Medicaid and Medicare, according to the most recently available calendar year data from the Illinois Health Care Cost Containment Council. Nothing in this paragraph shall preclude a hospital and an ambulatory surgical treatment center from forming a joint venture or developing a collaborative agreement to own or operate a postsurgical recovery care center.

(a-10) There shall be no more than a total of 8 children's respite care center alternative health care models in the demonstration program, which shall be located as follows:

(1) One in the City of Chicago.

(2) One in Cook County outside the City of Chicago.

(3) A total of 2 in the area comprised of DuPage, Kane, Lake, McHenry, and Will counties.

(4) A total of 2 in municipalities with a population of 50,000 or more and not located in the areas described in paragraphs (1), (2), or (3).

(5) A total of 2 in rural areas, as defined by the Health Facilities Planning Board.

No more than one children's respite care model owned and operated by a licensed skilled pediatric facility shall be located in each of the areas designated in this subsection (a-10).

(a-15) There shall be an authorized community-based residential rehabilitation center alternative health care model in the demonstration program. The community-based residential rehabilitation center shall be located in the area of Illinois south of Interstate Highway 70.

(a-20) There shall be an authorized Alzheimer's disease management center alternative health care model in the demonstration program. The Alzheimer's disease management center shall be located in Will County, owned by a not-for-profit entity, and endorsed by a resolution approved by the county board before the effective date of this amendatory Act of the 91st General Assembly.

(a-25) There shall be no more than 10 birth center alternative health care models in the demonstration program, located as follows:

(1) Four in the area comprising Cook, DuPage, Kane, Lake, McHenry, and Will counties, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(2) Three in municipalities with a population of 50,000 or more not located in the area described in paragraph (1) of this subsection, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(3) Three in rural areas, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

The first 3 birth centers authorized to operate by the Department shall be located in or predominantly serve the residents of a health professional shortage area as determined by the United States Department of Health and Human Services. There shall be no more than 2 birth centers authorized to operate in any single health planning area for obstetric services as determined under the Illinois Health Facilities Planning Act. If a birth center is located outside of a health professional shortage area, (i) the birth center shall be located in a health planning area with a demonstrated need for obstetrical service beds, as determined by the Illinois Health Facilities Planning Board or (ii) there must be a reduction in the existing number of obstetrical service beds in the planning area so that the establishment of the birth center does not result in an increase in the total number of obstetrical service beds in the health planning area.

(b) Alternative health care models, other than a model authorized under subsection (a-20), shall obtain a certificate of need from the Illinois Health Facilities Planning Board

under the Illinois Health Facilities Planning Act before receiving a license by the Department. If, after obtaining its initial certificate of need, an alternative health care delivery model that is a community based residential rehabilitation center seeks to increase the bed capacity of that center, it must obtain a certificate of need from the Illinois Health Facilities Planning Board before increasing the bed capacity. Alternative health care models in medically underserved areas shall receive priority in obtaining a certificate of need.

(c) An alternative health care model license shall be issued for a period of one year and shall be annually renewed if the facility or program is in substantial compliance with the Department's rules adopted under this Act. A licensed alternative health care model that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual renewals unless and until a different licensure program for that type of health care model is established by legislation. The Department may issue a provisional license to any alternative health care model that does not substantially comply with the provisions of this Act and the rules adopted under this Act if (i) the Department finds that the alternative health care model has undertaken changes and corrections which upon completion will render the alternative health care model in substantial compliance with this Act and rules and (ii) the health and safety of the patients of the alternative health care model will be protected during the period for which the provisional license is issued. The Department shall advise the licensee of the conditions under which the provisional license is issued, including the manner in which the alternative health care model fails to comply with the provisions of this Act and rules, and the time within which the changes and corrections necessary for the alternative health care model to substantially comply with this Act and rules shall be completed.

(d) Alternative health care models shall seek certification under Titles XVIII and XIX of the federal Social Security Act. In addition, alternative health care models shall provide charitable care consistent with that provided by comparable health care providers in the geographic area.

(d-5) The Department of Healthcare and Family Services (formerly Illinois Department of Public Aid), in cooperation with the Illinois Department of Public Health, shall develop and implement a reimbursement methodology for all facilities participating in the demonstration program. The Department of Healthcare and Family Services shall keep a record of services provided under the demonstration program to recipients of medical assistance under the Illinois Public Aid Code and shall submit an annual report of that information to the Illinois Department of Public Health.

(e) Alternative health care models shall, to the extent possible, link and integrate their services with nearby health care facilities.

(f) Each alternative health care model shall implement a

quality assurance program with measurable benefits and at reasonable cost.
(Source: P.A. 95-331, eff. 8-21-07; 95-445, eff. 1-1-08.)

(210 ILCS 3/35)

Sec. 35. Alternative health care models authorized. Notwithstanding any other law to the contrary, alternative health care models described in this Section may be established on a demonstration basis.

(1) Alternative health care model; subacute care hospital. A subacute care hospital is a designated site which provides medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. The average length of stay for patients treated in subacute care hospitals shall not be less than 20 days, and for individual patients, the expected length of stay at the time of admission shall not be less than 10 days. Variations from minimum lengths of stay shall be reported to the Department. There shall be no more than 13 subacute care hospitals authorized to operate by the Department. Subacute care includes physician supervision, registered nursing, and physiological monitoring on a continual basis. A subacute care hospital is either a freestanding building or a distinct physical and operational entity within a hospital or nursing home building. A subacute care hospital shall only consist of beds currently existing in licensed hospitals or skilled nursing facilities, except, in the City of Chicago, on a designated site that was licensed as a hospital under the Illinois Hospital Licensing Act within the 10 years immediately before the application for an alternative health care model license. During the period of operation of the demonstration project, the existing licensed beds shall remain licensed as hospital or skilled nursing facility beds as well as being licensed under this Act. In order to handle cases of complications, emergencies, or exigent circumstances, a subacute care hospital shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital. If a subacute care model is located in a general acute care hospital, it shall utilize all or a portion of the bed capacity of that existing hospital. In no event shall a subacute care hospital use the word "hospital" in its advertising or marketing activities or represent or hold itself out to the public as a general acute care hospital.

(2) Alternative health care delivery model; postsurgical recovery care center. A postsurgical recovery care center is a designated site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that require overnight nursing care, pain control, or observation that would

otherwise be provided in an inpatient setting. A postsurgical recovery care center is either freestanding or a defined unit of an ambulatory surgical treatment center or hospital. No facility, or portion of a facility, may participate in a demonstration program as a postsurgical recovery care center unless the facility has been licensed as an ambulatory surgical treatment center or hospital for at least 2 years before August 20, 1993 (the effective date of Public Act 88-441). The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 48 hours unless the treating physician requests an extension of time from the recovery center's medical director on the basis of medical or clinical documentation that an additional care period is required for the recovery of a patient and the medical director approves the extension of time. In no case, however, shall a patient's length of stay in a postsurgical recovery care center be longer than 72 hours. If a patient requires an additional care period after the expiration of the 72-hour limit, the patient shall be transferred to an appropriate facility. Reports on variances from the 48-hour limit shall be sent to the Department for its evaluation. The reports shall, before submission to the Department, have removed from them all patient and physician identifiers. In order to handle cases of complications, emergencies, or exigent circumstances, every postsurgical recovery care center as defined in this paragraph shall maintain a contractual relationship, including a transfer agreement, with a general acute care hospital. A postsurgical recovery care center shall be no larger than 20 beds. A postsurgical recovery care center shall be located within 15 minutes travel time from the general acute care hospital with which the center maintains a contractual relationship, including a transfer agreement, as required under this paragraph.

No postsurgical recovery care center shall discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

The Department shall adopt rules to implement the provisions of Public Act 88-441 concerning postsurgical recovery care centers within 9 months after August 20, 1993.

(3) Alternative health care delivery model; children's community-based health care center. A children's community-based health care center model is a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term stays and 120 days to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. This care is to be provided in a home-like

environment that serves no more than 12 children at a time. Children's community-based health care center services must be available through the model to all families, including those whose care is paid for through the Department of Healthcare and Family Services, the Department of Children and Family Services, the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home.

Each children's community-based health care center model location shall be physically separate and apart from any other facility licensed by the Department of Public Health under this or any other Act and shall provide the following services: respite care, registered nursing or licensed practical nursing care, transitional care to facilitate home placement or other appropriate settings and reunite families, medical day care, weekend camps, and diagnostic studies typically done in the home setting.

Coverage for the services provided by the Department of Healthcare and Family Services under this paragraph (3) is contingent upon federal waiver approval and is provided only to Medicaid eligible clients participating in the home and community based services waiver designated in Section 1915(c) of the Social Security Act for medically frail and technologically dependent children or children in Department of Children and Family Services foster care who receive home health benefits.

(4) Alternative health care delivery model; community based residential rehabilitation center. A community-based residential rehabilitation center model is a designated site that provides rehabilitation or support, or both, for persons who have experienced severe brain injury, who are medically stable, and who no longer require acute rehabilitative care or intense medical or nursing services. The average length of stay in a community-based residential rehabilitation center shall not exceed 4 months. As an integral part of the services provided, individuals are housed in a supervised living setting while having immediate access to the community. The residential rehabilitation center authorized by the Department may have more than one residence included under the license. A residence may be no larger than 12 beds and shall be located as an integral part of the community. Day treatment or individualized outpatient services shall be provided for persons who reside in their own home. Functional outcome goals shall be established for each individual. Services shall include, but are not limited to, case management, training and assistance with activities of daily living, nursing consultation, traditional therapies (physical, occupational, speech), functional interventions in the residence and community (job placement, shopping, banking, recreation), counseling, self-management strategies, productive activities, and multiple opportunities for skill

acquisition and practice throughout the day. The design of individualized program plans shall be consistent with the outcome goals that are established for each resident. The programs provided in this setting shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The program shall have been accredited by CARF as a Brain Injury Community-Integrative Program for at least 3 years.

(5) Alternative health care delivery model; Alzheimer's disease management center. An Alzheimer's disease management center model is a designated site that provides a safe and secure setting for care of persons diagnosed with Alzheimer's disease. An Alzheimer's disease management center model shall be a facility separate from any other facility licensed by the Department of Public Health under this or any other Act. An Alzheimer's disease management center shall conduct and document an assessment of each resident every 6 months. The assessment shall include an evaluation of daily functioning, cognitive status, other medical conditions, and behavioral problems. An Alzheimer's disease management center shall develop and implement an ongoing treatment plan for each resident. The treatment plan shall have defined goals. The Alzheimer's disease management center shall treat behavioral problems and mood disorders using nonpharmacologic approaches such as environmental modification, task simplification, and other appropriate activities. All staff must have necessary training to care for all stages of Alzheimer's Disease. An Alzheimer's disease management center shall provide education and support for residents and caregivers. The education and support shall include referrals to support organizations for educational materials on community resources, support groups, legal and financial issues, respite care, and future care needs and options. The education and support shall also include a discussion of the resident's need to make advance directives and to identify surrogates for medical and legal decision-making. The provisions of this paragraph establish the minimum level of services that must be provided by an Alzheimer's disease management center. An Alzheimer's disease management center model shall have no more than 100 residents. Nothing in this paragraph (5) shall be construed as prohibiting a person or facility from providing services and care to persons with Alzheimer's disease as otherwise authorized under State law.

(6) Alternative health care delivery model; birth center. A birth center shall be exclusively dedicated to serving the childbirth-related needs of women and their newborns and shall have no more than 10 beds. A birth center is a designated site that is away from the mother's usual place of residence and in which births are planned to occur following a normal, uncomplicated, and low-risk pregnancy. A birth center shall offer prenatal care and community education services and shall coordinate these

services with other health care services available in the community.

(A) A birth center shall not be separately licensed if it is one of the following:

(1) A part of a hospital; or

(2) A freestanding facility that is physically distinct from a hospital but is operated under a license issued to a hospital under the Hospital Licensing Act.

(B) A separate birth center license shall be required if the birth center is operated as:

(1) A part of the operation of a federally qualified health center as designated by the United States Department of Health and Human Services; or

(2) A facility other than one described in subparagraph (A)(1), (A)(2), or (B)(1) of this paragraph (6) whose costs are reimbursable under Title XIX of the federal Social Security Act.

In adopting rules for birth centers, the Department shall consider: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code. The Department's rules shall stipulate the eligibility criteria for birth center admission. The Department's rules shall stipulate the necessary equipment for emergency care according to the American Association of Birth Centers' standards and any additional equipment deemed necessary by the Department. The Department's rules shall provide for a time period within which each birth center not part of a hospital must become accredited by either the Commission for the Accreditation of Freestanding Birth Centers or The Joint Commission.

A birth center shall be certified to participate in the Medicare and Medicaid programs under Titles XVIII and XIX, respectively, of the federal Social Security Act. To the extent necessary, the Illinois Department of Healthcare and Family Services shall apply for a waiver from the United States Health Care Financing Administration to allow birth centers to be reimbursed under Title XIX of the federal Social Security Act.

A birth center that is not operated under a hospital license shall be located within a ground travel time distance from the general acute care hospital with which the birth center maintains a contractual relationship, including a transfer agreement, as required under this paragraph, that allows for an emergency caesarian delivery to be started within 30 minutes of the decision a caesarian delivery is necessary. A birth center operating under a hospital license shall be located within a ground travel time distance from the licensed hospital that allows for an emergency caesarian delivery to be started

within 30 minutes of the decision a caesarian delivery is necessary.

The services of a medical director physician, licensed to practice medicine in all its branches, who is certified or eligible for certification by the American College of Obstetricians and Gynecologists or the American Board of Osteopathic Obstetricians and Gynecologists or has hospital obstetrical privileges are required in birth centers. The medical director in consultation with the Director of Nursing and Midwifery Services shall coordinate the clinical staff and overall provision of patient care. The medical director or his or her physician designee shall be available on the premises or within a close proximity as defined by rule. The medical director and the Director of Nursing and Midwifery Services shall jointly develop and approve policies defining the criteria to determine which pregnancies are accepted as normal, uncomplicated, and low-risk, and the anesthesia services available at the center. No general anesthesia may be administered at the center.

If a birth center employs certified nurse midwives, a certified nurse midwife shall be the Director of Nursing and Midwifery Services who is responsible for the development of policies and procedures for services as provided by Department rules.

An obstetrician, family practitioner, or certified nurse midwife shall attend each woman in labor from the time of admission through birth and throughout the immediate postpartum period. Attendance may be delegated only to another physician or certified nurse midwife. Additionally, a second staff person shall also be present at each birth who is licensed or certified in Illinois in a health-related field and under the supervision of the physician or certified nurse midwife in attendance, has specialized training in labor and delivery techniques and care of newborns, and receives planned and ongoing training as needed to perform assigned duties effectively.

The maximum length of stay in a birth center shall be consistent with existing State laws allowing a 48-hour stay or appropriate post-delivery care, if discharged earlier than 48 hours.

A birth center shall participate in the Illinois Perinatal System under the Developmental Disability Prevention Act. At a minimum, this participation shall require a birth center to establish a letter of agreement with a hospital designated under the Perinatal System. A hospital that operates or has a letter of agreement with a birth center shall include the birth center under its maternity service plan under the Hospital Licensing Act and shall include the birth center in the hospital's letter of agreement with its regional perinatal center.

A birth center may not discriminate against any patient requiring treatment because of the source of payment for services, including Medicare and Medicaid recipients.

No general anesthesia and no surgery may be performed at a birth center. The Department may by rule add birth center patient eligibility criteria or standards as it deems necessary. The Department shall by rule require each birth center to report the information which the Department shall make publicly available, which shall include, but is not limited to, the following:

(i) Birth center ownership.

(ii) Sources of payment for services.

(iii) Utilization data involving patient length of stay.

(iv) Admissions and discharges.

(v) Complications.

(vi) Transfers.

(vii) Unusual incidents.

(viii) Deaths.

(ix) Any other publicly reported data required under the Illinois Consumer Guide.

(x) Post-discharge patient status data where patients are followed for 14 days after discharge from the birth center to determine whether the mother or baby developed a complication or infection.

Within 9 months after the effective date of this amendatory Act of the 95th General Assembly, the Department shall adopt rules that are developed with consideration of: the American Association of Birth Centers' Standards for Freestanding Birth Centers; the American Academy of Pediatrics/American College of Obstetricians and Gynecologists Guidelines for Perinatal Care; and the Regionalized Perinatal Health Care Code.

The Department shall adopt other rules as necessary to implement the provisions of this amendatory Act of the 95th General Assembly within 9 months after the effective date of this amendatory Act of the 95th General Assembly.
(Source: P.A. 95-331, eff. 8-21-07; 95-445, eff. 1-1-08.)

(210 ILCS 3/35.1)

Sec. 35.1. Scope of Program for Recovery Centers. Once the Department has authorized a total of 12 postsurgical recovery care centers under this Act, no new centers shall be authorized for the duration of the demonstration program.
(Source: P.A. 89-393, eff. 8-20-95.)

(210 ILCS 3/36)

Sec. 36. Use of name; patient transfers; consulting committee. No facility or person shall hold itself out to the public as a "recovery care center" or "postsurgical recovery care center" unless it is licensed as a postsurgical recovery care center under this Act.

The Department shall establish by rule criteria for patient transfers to postsurgical recovery care models. Each

facility licensed as a postsurgical recovery care center shall establish a qualified consulting committee to review the types of surgical procedures performed in ambulatory surgical treatment centers and hospitals which intend to transfer patients to the recovery care center. The committee shall recommend appropriate procedures for approval by the Department of Public Health. Action on these recommendations by the Department shall not be unreasonably withheld.
(Source: P.A. 88-490.)

(210 ILCS 3/36.5)

Sec. 36.5. Alternative health care models authorized. Notwithstanding any other law to the contrary, alternative health care models described in part 1 of Section 35 shall be licensed without additional consideration by the Illinois Health Facilities Planning Board if:

(1) an application for such a model was filed with the Illinois Health Facilities Planning Board prior to September 1, 1994;

(2) the application was received by the Illinois Health Facilities Planning Board and was awarded at least the minimum number of points required for approval by the Board or, if the application was withdrawn prior to Board action, the staff report recommended at least the minimum number of points required for approval by the Board; and

(3) the applicant complies with all regulations of the Illinois Department of Public Health to receive a license pursuant to part 1 of Section 35.

(Source: P.A. 89-393, eff. 8-20-95.)

(210 ILCS 3/40)

Sec. 40. Demonstration program funding. The Regulatory Evaluation and Basic Enforcement Fund is created in the State treasury to collect application fees, renewal fees, and fines collected under this Act. Moneys shall be appropriated from the Fund to the Department to implement its administrative, licensure, and evaluation functions under this Act.
(Source: P.A. 87-1188.)

(210 ILCS 3/45)

Sec. 45. License denial, suspension, or revocation. A license may be denied, suspended, or revoked, or the renewal of a license may be denied, for any of the following reasons:

(1) Violation of any provision of this Act or the rules adopted by the Department under this Act.

(2) Conviction of the owner or operator of the alternative health care model (i) of a felony or (ii) of any other crime under the laws of any state or of the United States arising out of or in connection with the

operation of a health care facility. The record of conviction or a certified copy of it shall be conclusive evidence of conviction.

(3) An encumbrance on a health care license issued in Illinois or any other state to the owner or operator of the alternative health care model.

(4) Revocation of any facility license issued by the Department during the previous 5 years or surrender or expiration of the license during the pendency of action by the Department to revoke or suspend the license during the previous 5 years, if (i) the prior license was issued to the individual applicant or a controlling owner or controlling combination of owners of the applicant or (ii) any affiliate of the individual applicant or controlling owner of the applicant or affiliate of the applicant was a controlling owner of the prior license.

(Source: P.A. 87-1188.)

(210 ILCS 3/50)

Sec. 50. Investigation of applicant or licensee; notice. The Department may on its own motion, and shall on the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for the denial of an application for a license, refusal to renew a license, suspension of a license, or revocation of a license, investigate the applicant or licensee. The Department, after notice and an opportunity for a hearing, may deny an application for a licensee, revoke a license, or refuse to renew a license under Section 45 of this Act. Before denying a license application, refusing to renew a license, suspending a license, or revoking a license, the Department shall notify the applicant or licensee in writing. The notice shall specify the charges or reasons for the Department's contemplated action. If the applicant or licensee desires a hearing on the Department's contemplated action, he or she must request a hearing within 10 days after receiving the notice. A failure to request a hearing within 10 days shall constitute a waiver of the applicant's or licensee's right to a hearing.

(Source: P.A. 87-1188.)

(210 ILCS 3/55)

Sec. 55. Hearings. The hearing requested under Sec. 50 shall be conducted by the Director or an individual designated in writing by the Director as a hearing officer. The Director or hearing officer may compel, by subpoena or subpoena duces tecum, the attendance and testimony of witnesses and the production of books and papers. The Director or hearing officer may administer oaths to witnesses. The hearing shall be conducted at a place designated by the Department. The procedures governing hearings and the issuance of final orders under this Act shall be according to rules adopted by the

Department. All subpoenas issued by the Director or hearing officer may be served as in civil actions. The fees of witnesses for attendance and travel shall be the same as the fees for witnesses before the circuit court and shall be paid by the party to the proceedings at whose request the subpoena is issued. If a subpoena is issued at the request of the Department, the witness fee shall be paid by the Department as an administrative expense. If a witness refuses to attend or testify, or to produce books or papers, concerning any matter on which he or she might be lawfully examined, the circuit court of the county in which the hearing is held, on application of any party to the proceeding, may compel obedience by a proceeding for contempt as in cases of a refusal to obey a similar order of the court.
(Source: P.A. 87-1188.)

(210 ILCS 3/60)

Sec. 60. Final orders. The Director or hearing officer shall make findings of fact and conclusions of law in the matters that are the subject of the hearing, and the Director shall render a decision, or the hearing officer a proposal for decision, within 45 days after the termination of the hearing unless additional time is required by the Director or hearing officer for a proper disposition of the matter. A copy of the final decision of the Director shall be served on the applicant or licensee in person or by certified mail.
(Source: P.A. 87-1188.)

(210 ILCS 3/65)

Sec. 65. Judicial review; deposit for costs.

(a) All final administrative decisions of the Department under this Act shall be subject to judicial review under the provisions of the Administrative Review Law and the rules adopted under that Law. "Administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure. Proceedings for judicial review shall be commenced in the circuit court of the county in which the party applying for review resides. If that party is not a resident of this State, however, the venue shall be in Sangamon County.

(b) The Department shall not be required to certify any record or file any answer or otherwise appear in any proceeding for judicial review unless the party filing the complaint deposits with the clerk of the circuit court the sum of $0.95 per page for the costs of certification. Failure by the plaintiff to make the deposit shall be grounds for dismissing the action.
(Source: P.A. 87-1188.)

(210 ILCS 3/70)
Sec. 70. Administrative rules. The Illinois Administrative Procedure Act is expressly adopted and shall apply to all rules of the Department adopted under this Act.
(Source: P.A. 87-1188.)

(210 ILCS 3/75)
Sec. 75. Violations; criminal penalties. Any person opening, conducting, or maintaining an alternative health care model without a license issued under this Act shall be guilty of a business offense punishable upon conviction by a fine of $10,000. Each day the violation continues shall constitute a separate offense.
(Source: P.A. 87-1188.)

(210 ILCS 3/80)
Sec. 80. Injunction. The operation or maintenance of an alternative health care model in violation of this Act or the rules adopted under this Act is declared to be inimical to the public welfare. The Director, in addition to other remedies provided in this Act, may bring an action in the name of the People of the State, through the Attorney General, for an injunction to restrain a violation of this Act or the rules or to enjoin the future operation or maintenance of the alternative health care model.
(Source: P.A. 87-1188.)

(210 ILCS 3/99)
Sec. 99. This Act shall take effect upon becoming law.
(Source: P.A. 87-1188.)

APPENDIX B:

CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER PROGRAM CODE

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES
PART 260 CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER PROGRAM CODE
SECTION 260.1000 DEFINITIONS

Section 260.1000 Definitions

The following terms shall have the meanings ascribed to them here whenever the term is used in this Part.

Abuse – any physical or mental injury or sexual assault inflicted on a patient other than by accidental means in a center. Abuse includes:

Physical abuse refers to the infliction of injury on a patient that occurs other than by accidental means and that requires (whether or not actually given) medical attention.

Mental injury arises from the following types of conduct:

Verbal abuse refers to the use by a licensee, employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to patients or within their hearing or seeing distance, regardless of their age, ability to comprehend or disability.

Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by a licensee, employee or agent.

Sexual harassment or sexual coercion perpetrated by a licensee, employee or agent.

Sexual assault.

Act – the Alternative Health Care Delivery Act [210 ILCS 3].

Affiliate –

With respect to a partnership, each partner thereof;

With respect to a corporation, each officer, director and stockholder thereof;

With respect to a natural person: any person related in the first degree of kinship to that person; each partnership and each partner thereof of which that person or any affiliate of that person is a partner; and each corporation in which that person or any affiliate of that person is an officer, director or stockholder.

Board – *the State Board of Health*. (Section 10 of the Act)

Charitable Care – the intentional provision of free or discounted services to persons who cannot afford to pay.

Children with Special Health Care Needs − those children who have or are at increased risk for chronic physical ailments who require health and related services of a type or amount beyond that required by children generally.

Children's Representative – a person authorized by law to act on behalf of the child.

Children's Community-Based Health Care Center or Center – *a designated site that provides nursing care, clinical support services, and therapies for a period of one to 14 days for short-term stays and* one to *120 days to facilitate transitions to home or other appropriate settings for medically fragile children, technology dependent children, and children with special health care needs who are deemed clinically stable by a physician and are younger than 22 years of age. This care is to be provided in a home-like environment that serves no more than 12 children at a time.* (Section 35(3) of the Act)

Demonstration Program or Program – *a program to license and study alternative health care models authorized under the Act*. (Section 10 of the Act)

Department – *the Illinois Department of Public Health*. (Section 10 of the Act)

Diagnostic Studies − any analytic tests, including, but not limited to, heart monitoring or sleep tests, used in identifying the nature or cause of an illness, disorder or problem that are typically done in the home and that are conducted in a Children's Community-Based Health Care Center for children with special health care needs.

Dietitian – a person who is a licensed dietitian as provided in the Dietetic and Nutrition Services Practice Act [225 ILCS 30].

Director – the *Director of Public Health* or designee. (Section 10 of the Act)

Hospital – a facility licensed pursuant to the Hospital Licensing Act [210 ILCS 85].

Inspection – any survey, evaluation or investigation of the Children's Community-Based Health Care Center Model's compliance with the Act and this Part by the Department or designee.

Licensee – the person or entity licensed to operate the Children's Community-Based Health Care Center Model.

Medical Day Care − care provided by a Children's Community-Based Health Care Center for children with special health care needs for no more than 12 in 24 hours, in accordance with Section 260.1800(c) of this Part.

Medically Fragile Children − children who are medically stable but require skilled nursing care, specialized therapy, and specialized medical equipment and supplies to enhance or sustain their lives. "Medically fragile children" may include, but is not limited to, children who have neuro-muscular disease, heart disease, cancer, seizure disorder, spina bifida, chronic lung disease, or other medical conditions that threaten the child's ability to thrive and to survive without proper medical care.

Neglect – a failure in a center to provide adequate medical or personal care or maintenance, resulting in physical or mental injury to a patient or in the deterioration of a patient's physical or mental condition. Neglect shall include any situation in which:

failure to provide adequate medical or personal care or maintenance causes injury or deterioration that is ongoing or repetitious; or

failure to provide adequate medical or personal care or maintenance results in a patient requiring medical treatment; or

failure to provide adequate medical or personal care or maintenance causes a noticeable negative impact on a patient's health, behavior or activities for more than 24 hours.

Physician – a person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60].

Registered Nurse – a person who is licensed as a registered professional nurse under the Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65].

Substantial Compliance – meeting requirements except for variance from the strict and literal performance, which results in unimportant omissions or defects given the particular circumstances involved. This definition is limited to the phrase as used in Section 260.1200.

Technology Dependent Children − medically fragile children who require the constant or regular intermittent use of technology to meet their medical needs. This may include, but is not limited to, devices that assist or support breathing, monitor bodily functions, or provide nutrition.

Weekend Camps − a planned program for medically fragile children, technology dependent children, or children with special health care needs that consists typically of Friday afternoon through Sunday evening.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1050 Incorporated and Referenced Materials

a) The following Illinois statutes and administrative rules of the Department of Public Health are referenced in this Part:

1) State of Illinois Statutes:

A) Hospital Licensing Act [210 ILCS 85]

B) Illinois Health Facilities Planning Act [20 ILCS 3960]

C) Medical Practice Act of 1987 [225 ILCS 60]

D) Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65]

E) Dietetic and Nutrition Services Practice Act [225 ILCS 30]

F) Abused and Neglected Child Reporting Act [325 ILCS 5]

2) Department of Public Health Administrative rules:

A) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

B) Control of Communicable Diseases Code (77 Ill. Adm. Code 690)

C) Food Service Sanitation Code (77 Ill. Adm. Code 750)

D) Drinking Water Systems Code (77 Ill. Adm. Code 900)

E) Public Area Sanitary Practice Code (77 Ill. Adm. Code 895)

F) Private Sewage Disposal Code (77 Ill. Adm. Code 905)

G) Control of Tuberculosis Code (77 Ill. Adm. Code 696)

b) The following private and professional association standards are incorporated in this Part:

National Fire Protection Association (NFPA) standard No. 101: Life Safety Code, 2000 edition, chapter 23, "Existing Residential Board and Care Occupancies, Impractical", which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169-7471.

c) All incorporations by reference of the standards of nationally recognized organizations refer to the standards on the date specified and do not include any amendments or editions subsequent to the date specified.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1100 Demonstration Program Elements

a) The Children's Community-Based Health Care Center Demonstration Program shall be reviewed annually by the Board to determine if it should continue operation for a period of up to five years, commencing with February 20, 1998.

b) A Children's Community-Based Health Care Center Model shall be licensed pursuant to this Part to be considered a participant in the Program.

c) Applications for participation in the Program shall be considered only when a vacancy exists in one of the allocated Program slots for the relevant geographic area.

d) *At the midpoint and end of the Program, the Board shall evaluate and make recommendations to the Governor and the General Assembly, through the Department, regarding the Program,* in accordance with Section 20(b) of the Act.

e) *The Department shall deposit all application fees, renewal fees and fines collected under the Act and this Part into the Regulatory Evaluation and Basic Enforcement Fund in the State Treasury. (Section 25(d) of the Act)*

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1200 Application for and Issuance of a License to Operate a Children's Community-Based Health Care Center Model

a) Applications for a license to operate a Children's Community-Based Health Care Center Model shall be in writing on forms provided by the Department. The application shall be made under oath and shall contain the following:

1) Proof of a Certificate of Need to establish and operate a Children's Community-Based Health Care Center Model issued by the Health Facilities Planning Board under the Illinois Health Facilities Planning Act [20 ILCS 3960];

2) The name of the proposed Model;

3) The address of the proposed Model;

4) A precise description of the site of the proposed Model;

5) The maximum occupancy of the Model;

6) The name and address of the registered agent or other individual authorized to receive Service of Process for the Model licensee;

7) The name of the person or persons under whose management or supervision the center will be operated;

8) Documentation of compliance with Section 260.2300 of this Part; and

9) The Model's admission policies and procedures in accordance with Section 260.1800 of this Part.

b) An application for initial licensure shall be accompanied by an application fee of $500 plus $100 for each bed.

c) Upon receipt and review of a complete application for licensure, the Department shall conduct an inspection to determine compliance with the Act and this Part.

d) If the proposed Model is found to be in substantial compliance with the Act and this Part, the Department shall issue a license for a period of one year. The license shall not be transferable; it is issued to the licensee and for the specific location and number of beds identified in the application.

e) An application for license renewal shall be filed with the Department 90 to 120 days prior to the expiration of the license, on forms provided by the Department.

1) The renewal application shall comply with the requirements of subsections (a) and (b) of this Section; and

2) Upon receipt and review of a complete application for license renewal, the Department may conduct a survey. The Department shall renew the license in accordance with subsection (d) of this Section.

f) *The Department may issue a provisional license to any* Children's Community-Based Health Care Center *Model that does not substantially comply with the provisions of the Act* and this Part:

1) A provisional license may be issued only *if the Department finds that*:

A) *The Model has undertaken changes and corrections which upon completion will render the Model in substantial compliance with the Act; and*

B) *The health and safety of the patients* in the Model *will be protected during the period for which the provisional license is issued.* (Section 30(c) of the Act)

2) *The Department shall advise the applicant or licensee of the conditions under which the provisional license is issued, including:*

A) *The manner in which the Model fails to comply with the provisions of the Act;*

B) The changes and corrections that shall be completed;

C) *The time within which the necessary changes and corrections shall be completed* (Section 30(c) of the Act); and

D) The interim actions that are necessary to protect the health and safety of the patients.

g) The Children's Community-Based Health Care Center Model license or provisional license shall be prominently displayed in an area accessible to the public.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1300 Obligations and Privileges of Children's Community-Based Health Care Center Models

a) Children's Community-Based Health Care Center Models *shall*, within 30 days after licensure, *seek certification under Titles XVIII and XIX of the federal Social Security Act.* (Section 30(d) of the Act) *Coverage for services provided by the Illinois Department of Healthcare and Family Services is contingent upon federal waiver approval and is provided only to Medicaid eligible clients participating in the Home and Community Based Services waiver designated in section1915(c) of the Social Security Act for medically frail and technologically dependent children.* (Section 35(3) of the Act)

b) Children's Community-Based Health Care Center Models *shall provide charitable care consistent with that provided by comparable health care providers in the geographic area.* (Section 30(d) of the Act)

c) *Children's Community-Based Health Care Center services must be available through the model to all families, including those whose care is paid for through the Department of Healthcare and Family Services, the Department of Children and Family Services, the Department of Human Services, and insurance companies who cover home health care services or private duty nursing care in the home.* (Section 35(3) of the Act)

d) *A licensed* Children's *Community-Based Health* Care Center Model *that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual* license *renewals unless and until a different licensure program for that type of health care model is established by legislation.* (Section 30(c) of the Act)

e) *Each* Children's *Community-Based Health Care* Center *Model location shall be physically separate and apart from any other facility licensed by the Department of Public Health.* (Section 35(3) of the Act)

f) Children's Community-Based Health Care Center Models *shall provide the following services: respite care; registered nursing or licensed practical nursing care; transitional care to facilitate home placement or other appropriate settings and reunite families; medical day care; weekend camps; and diagnostic studies typically done in the home setting.* (Section 35(3) of the Act)

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1400 Inspections and Investigations

a) *The Department shall perform licensure inspections of* Children's Community-Based Health Care Center *Models, as deemed necessary, to ensure compliance with the Act* and this Part. (Section 25(c) of the Act)

b) All centers to which this Part applies shall be subject to and shall be deemed to have given consent to all inspections by properly identified personnel of the Department, or by other such properly identified persons as the Department might designate. In addition, representatives of the Department shall have access to and may reproduce or photocopy any books, records and other documents maintained by the center or the licensee to the extent necessary to carry out the Act and this Part.

c) *The Department shall investigate an applicant or licensee* whenever it receives *a verified complaint in writing of any person setting forth facts which, if proven, would constitute grounds for the denial of an application for a license, refusal to renew a license, or suspension or revocation of a license.* (Section 50 of the Act)

d) *The Department may* also *investigate an applicant or licensee on its own motion* or based upon complaints received by mail, telephone or in person. (Section 50 of the Act)

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1500 Notice of Violation and Plan of Correction

a) Upon determination that the licensee or applicant is in violation of the Act or this Part, the Department shall issue a written Notice of Violation and request a plan of correction. The notice shall specify the violations, and shall instruct the

licensee or applicant to submit a plan of correction to the Department within 10 days after receipt of the Notice.

b) Within the ten-day period, a licensee or applicant may request additional time for submission of the plan of correction. The Department may extend the period for submission of the plan of correction for an additional 30 days, when the Department finds that corrective action by a facility to abate or eliminate the violation will require substantial capital improvement. The Department will consider the extent and complexity of necessary physical plant repairs and improvements and any impact on the health, safety, or welfare of the patients of the facility in determining whether to grant a requested extension.

c) Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures which have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the Notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.

3) A specific date by which the corrective action will be completed.

d) Submission of a plan of correction shall not be considered an admission by the facility that the violation has occurred.

e) The Department shall review each plan of correction to ensure that it provides for the abatement, elimination, or correction of the violation. The Department shall reject a submitted plan only if it finds any of the following deficiencies:

1) The plan does not appear to address the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences.

2) The plan is not specific enough to indicate the actual actions the facility will be taking to abate, eliminate, or correct the violation.

3) The plan does not provide for measures that will abate, eliminate, or correct the violation.

4) The plan does not provide steps that will avoid future occurrences of the same and similar violations.

5) The plan does not provide for timely completion of the corrective action, considering the seriousness of the violation, any possible harm to the patients, and the extent and complexity of the corrective action.

f) The Department shall notify the licensee or applicant in writing of the acceptance or rejection of the plan of correction, including specific reasons for the rejection of the plan. The facility shall have 10 days after receipt of notice of rejection in which to submit a modified plan that addresses the requirements of subsection (c) of this Section.

g) If a licensee or applicant fails to make a timely submission of a modified plan of correction, or such modified plan is not acceptable to the Department, a plan of correction shall be specified and imposed by the Department.

h) The Department shall verify the completion of the corrective action required by the plan of correction within the specified time period during subsequent investigations, surveys and evaluations of the facility.

Section 260.1600 Adverse Licensure Action

a) *Before denying a license application, refusing to renew a license, suspending a license, revoking a license* or assessing an administrative fine, *the Department shall notify the applicant or the licensee in writing. The notice shall specify the charges or reasons for the Department's contemplated action,* and shall provide an opportunity to file a request for a hearing *within 10 days after receiving the notice.* (Section 50 of the Act)

1) *A failure to request a hearing within 10 days shall constitute a waiver of the applicant's or licensee's right to a hearing.* (Section 50 of the Act)

2) *The hearing shall be conducted by the Director or an individual designated in writing by the Director as* an Administrative Law Judge, and shall be conducted in conformance with the Department's Rules of Practice and Procedure in Administrative Hearings and the Act. (Section 55 of the Act)

b) A license *may be denied, suspended, or revoked, or the renewal of a license may be denied* or an administrative fine assessed, *for any of the following reasons:*

1) *Violation of any provision of the Act* or this Part;

2) *Conviction of the owner or operator of the* Children's Respite Care Center Model *of a felony or of any other crime under the laws of any state or of the United States arising out of, or in connection with, the operation of a health care facility. The record of conviction or a certified copy of it shall be conclusive evidence of conviction;*

3) *An encumbrance on a health care license issued in Illinois or any other state to the owner or operator of the* Children's Respite Care Center Model;

4) *Revocation of any facility license issued by the Department during the previous five years or surrender or expiration of the license during the pendency of action by the Department to revoke or suspend the license during the previous five years if:*

A) *The prior license was issued to the individual applicant or a controlling owner or controlling combination of owners of the applicant; or*

B) *Any affiliate or the individual applicant or controlling owner of the applicant or affiliate of the applicant was a controlling owner of the prior license.* (Section 45 of the Act)

c) An action to assess an administrative fine may be initiated in conjunction with or in lieu of other adverse licensure action.

d) The amount of an administrative fine shall be determined based on consideration of the following:

1) The nature and severity of the violation(s);

2) The facility's diligence in correcting the violation(s);

3) Whether the facility had been previously cited for similar violation(s);

4) The number of violation(s);

5) The duration of uncorrected violation(s); and

6) The impact or potential impact of the violation(s) on the children's health and safety.

e) The administrative fine shall be calculated in relation to the number of days the violation existed, or continues to exist if it has not been corrected. The total amount of the fine assessed shall fall within the following parameters:

1) For a violation that occurred as a single event or incident – between $100 and $5,000 per violation;

2) For a violation that was or is continuing beyond a single event or incident – between $100 and $500 per day per violation.

Section 260.1700 Policies and Procedures

a) The facility shall have policies and procedures that implement and are consistent with the provisions of this Part.

b) The facility shall have infection control policies and procedures, which shall include at least the following:

1) Compliance with the Department's rules entitled "Control of Communicable Diseases Code" (77 Ill. Adm. Code 690);

2) The use of universal precautions and isolation techniques;

3) A continuing program of instruction for all personnel on the mode of spread of infections; and

4) Posted handwashing techniques.

c) The facility shall provide for the registration and disposition of complaints without threat of discharge or other reprisal against any employee, volunteer, child or child's representative.

d) The facility shall have policies covering disaster preparedness, including a written plan for staff and children to follow in case of fire, explosion, severe weather or other hazardous circumstance or emergency.

1) All personnel shall be trained in the proper use of a fire extinguisher.

2) All personnel shall be trained in the evacuation plan.

e) The facility shall develop, with the approval of the medical director, policies and procedures to be followed during various medical emergencies. The types of medical emergencies addressed should be based on the needs of the children being served and may include, but are not limited to, foreign body aspiration, poisoning, allergic reactions, asthma, convulsions, insulin shock, and acute respiratory distress.

Section 260.1750 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

(Source: Amended at 30 Ill. Reg. 883, effective January 9, 2006)

Section 260.1800 Admission and Participation Practices

a) The center shall establish admission criteria for short-term stays that provide for:

1) The admission of children for no more than 14 days;

2) The admission of children whose service plan can be met by the center; and

3) Nondiscrimination toward children or their families based on disability, race, religion, sex, source of payment, and any other basis recognized by applicable State and federal laws.

b) To facilitate transitions to home or other appropriate settings, the center shall establish admission criteria that provide for:

1) The admission of children for no more than 120 days;

2) The admission of children whose service plan can be met by the center; and

3) Nondiscrimination toward children or their families based on disability, race, religion, sex, source of payment, and any other basis recognized by applicable State and federal laws.

c) The center shall establish participation criteria for medical day care that provide for:

1) The participation of children for no more than 12 hours in 24 hours;

2) The participation of children whose service plan can be met by the center; and

3) Nondiscrimination toward children or their families based on disability, race, religion, sex, source of payment, and any other basis recognized by applicable State and federal laws.

d) The center shall establish participation criteria for weekend camps that provide for:

1) The participation of children whose service plan can be met by the center; and

2) Nondiscrimination toward children or their families based on disability, race, religion, sex, source of payment, and any other basis recognized by applicable State and federal laws.

e) The center shall establish criteria for diagnostic studies that provide for:

1) Conducting only those diagnostic studies ordered by a physician and that are typically conducted in the home;

2) Meeting all provisions for short-term stays, in accordance with subsection (a), if children are admitted overnight;

3) The participation of children whose service plan can be met by the center; and

4) Nondiscrimination toward children or their families based on disability, race, religion, sex, source of payment, and any other basis recognized by applicable State and federal laws.

f) At the time each child is admitted, the licensee must assure that the center has conducted an assessment and has a service plan to meet the child's needs. A service plan shall consist of at least the following:

1) Provided by the parent or child's representative:

A) a description of the child's usual routine,

B) the child's food preferences,

C) the child's allergies, if any,

D) instructions for the child's personal care,

E) information on the child's educational program, if applicable,

F) an emergency phone number where the parents, guardian or other responsible person can be contacted during the child's stay, and

G) any other information that will help the child's stay to be safe and enjoyable.

2) Provided by a physician:

A) medication orders, if any,

B) treatments, if any,

C) nursing orders, if any,

D) any activity restrictions,

E) documentation of the child's current immunization status, and

F) any other information that will help the child's stay to be safe and enjoyable.

g) Only those children shall be admitted or served for whom the center has the trained personnel, equipment, and supplies to meet the service plan.

h) A personal physician shall be identified for each child admitted. The service plan shall document the method for contacting this physician at any time.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.1900 Child's Rights

a) A child shall not be deprived of any rights, benefits, or privileges guaranteed by law based solely on his/her status as a patient of the facility.

b) A child shall be permitted to retain and use or wear his/her personal property in his/her immediate living quarters unless deemed medically inappropriate or socially disruptive by a physician and so documented in the patient's record.

c) The facility shall make reasonable efforts to prevent loss and theft of children's property. The facility shall develop procedures for investigating complaints concerning theft of children's property and shall promptly investigate all such complaints.

d) Children under 16 years of age who are related to employees or volunteers of a facility, and who are not themselves employees/volunteers of the facility, shall be restricted to quarters reserved for family or employee use except during times when such children are part of a group visiting the facility as part of a planned program, or similar activity.

e) A child shall be permitted the free exercise of religion. Upon the child's request, and if necessary at his/her expense, the facility management shall make arrangements for a child's attendance at religious services of the child's choice. However, no religious beliefs or practices, or attendance at religious services, may be imposed upon any child.

f) The facility shall notify the child's parent or child's representative whenever the child suffers from a sudden illness or accident, or if and when unexplained absences occur.

g) A child may not be transferred, discharged, evicted, harassed, dismissed or retaliated against for filing a complaint or providing information concerning a complaint against the facility.

h) A child shall be permitted to retain the services of his/her own personal physician at his/her own expense, under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage.

i) No child shall be subjected to experimental research or treatment without first obtaining his/her parent's, or his/her representative's, informed written consent. The experimental research/treatment shall be part of the child's service plan.

j) Every child's representative shall be permitted to refuse medical treatment for the child and to know the consequences of such action.

k) Every child or child's representative shall be permitted to inspect and copy all of the child's clinical and other records concerning the child's care and maintenance kept by the facility or by the child's physician.

l) All children shall be permitted respect and privacy in their medical and personal care program. Every child's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly. Those persons not directly involved in the child's care must have the permission of the child's representative to be present.

m) Neither physical restraints nor confinements shall be employed for the purpose of punishment or for the convenience of any facility personnel or volunteer. High chairs, playpens, cribs or youth beds are not restraints for children less than 4 years old.

n) Restraints shall be used only for the safety and security of the child upon written order of the attending physician and with the informed consent of the child's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints or confinements shall be employed. The reasons for ordering and using restraints shall be recorded in the child's service plan.

o) The facility management shall ensure that children may have private visits at any reasonable hour unless such visits are not medically advisable for the child or are contrary to the directions of the child's representative as documented in the child's service plan. The facility shall allow daily visiting. Visiting hours shall be posted in plain view of visitors. The facility management shall ensure that space for visits is available and that facility personnel knock, except in an emergency, before entering any child's room.

p) No visitor shall enter the immediate living area of any child without first identifying himself/herself and then receiving permission from the child to enter. The rights of other children present in the room shall be respected. Facility staff may terminate visits or provide other accommodations for the visit if they are so requested by the child, or the visitor is involved in behavior violating other children's rights.

q) A child shall be voluntarily discharged from a facility after the child's representative gives facility management, a physician, or a nurse of the facility written notice of the desire to be discharged. A child shall be discharged upon written consent of the child's representative unless there is a court order to the contrary. In such cases, upon the child's discharge, the facility is relieved of any responsibility for the child's care, safety or well-being.

r) The facility shall establish involuntary discharge procedures in accordance with subsection (s) of this Section, which shall include at least the following:

1) Child's behavior that may result in involuntary discharge;

2) Child's decline in medical condition that may result in involuntary discharge;

3) Child, parent, and child's representative counseling that may be provided to avoid involuntary discharge;

4) Child's parent and child's representative notification concerning involuntary discharge; and

5) Time frames between counseling, notice, and involuntary discharge.

s) A facility may involuntarily transfer or discharge a child only for one or more of the following reasons:

1) The child's medical condition;

2) The child's physical safety; and

3) The child's action that directly impinges on the physical safety of other children, the facility staff or facility visitors.

t) A licensee, facility manager, employee, volunteer or agent of a facility shall not abuse or neglect a child.

u) A facility employee, agent or volunteer who becomes aware of abuse or neglect of a child shall immediately report the matter to the facility manager or designee.

v) Upon becoming aware of abuse or neglect, the facility manager or designee shall immediately report the matter by telephone and in writing to the child's representative and the Department.

Section 260.2000 Child Care Services

a) No more than 12 children shall be served at a time.

b) The licensee shall provide services as necessary to implement and support the child's service plan and overall needs, including provisions for:

1) Case management;

2) Fostering maximum independence of the child; and

3) Protection of the child's rights, privacy and dignity.

c) The licensee shall have one or more transfer agreements with hospitals to provide emergency care to children.

d) The licensee shall provide recreational and leisure activities for children during their stay.

e) A written summary of the child's stay shall be sent home with each child. The summary shall contain documentation of any extreme (positive or negative) occurrences and any information that will increase continuity of services.

f) All information related to the child, the child's representative or the child's service plan is confidential and shall be accessible only to those individuals who need the information to assure appropriate service delivery.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.2100 Medication Administration

a) Except for medications allowed in subsection (b) of this Section, the only medications allowed in the facility are those for particular individual children. The medication of each child shall be kept and stored in the original container received from the pharmacy.

1) Each multidose medication container shall indicate the child's name, physician's name, prescription number, name, strength and quantity of drug, date this container was last filled, the initials of the pharmacist filling the prescription, the identity of the pharmacy, the refill date and any necessary special instructions.

2) Each single unit or unit dose package shall contain the proprietary and nonproprietary name of the drug and the strength of the dose. The name of the child and the physician do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the correct resident.

b) A facility may stock a small supply of medications regularly available without prescription at a commercial pharmacy, such as: noncontrolled cough syrups, laxatives, and analgesics. These shall be given to a child only upon the order of a physician.

c) The facility shall have a first aid kit that contains items appropriate to treat minor cuts, burns, abrasions, etc.

d) All medications shall be properly stored in a secured location not accessible to unauthorized individuals.

e) All medications shall be sent home with the child for whom the medication was prescribed.

Section 260.2200 Personnel

a) Each center shall develop and maintain written personnel policies that are followed in the operation of the center.

b) The center shall establish policies to screen all current and prospective employees and volunteers that shall include at least the following:

1) Conduct a check of the Department of Children and Family Services (DCFS) Central Registry, in a form and a manner prescribed by DCFS.

2) Conduct a check of the Sex Offender Registry in a form and a manner prescribed by the Illinois State Police (ISP).

3) Maintain records of these checks in the employee's personnel file or the volunteer's file.

c) The center shall define in policy whether individuals with findings on the DCFS Central Registry will be eligible for hire or to volunteer and, if so, the Center shall define the level of supervision that will be provided.

d) All employees and volunteers shall be considered mandated reporters as defined in the Abused and Neglected Child Reporting Act.

1) Reports of suspected child abuse or neglect shall be immediately reported to the DCFS State Central Registry (1-800-25A-BUSE) or local law enforcement.

2) Reports of suspected child abuse or neglect shall be immediately reported to the Department of Public Health's Central Complaint Registry (1-800-252-4343).

3) The center shall provide orientation to current staff and volunteers within 30 days after September 30, 2006 regarding their responsibilities under the Abused and Neglected Child Reporting Act.

4) The center shall provide orientation to new staff and volunteers within 14 days after the first day of employment or volunteering.

5) This orientation shall include, at least, definitions of what constitutes abuse and neglect, the individual's responsibility under the Abused and Neglected Child Reporting Act, and the center's policy on reporting abuse and neglect.

e) Each employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, children or visitors.

1) The initial health evaluation shall be completed no more than 30 days prior to or 30 days after the employee's first day of employment.

2) The initial health evaluation shall include a health inventory from the employee, including an evaluation of the employee's immunization status.

3) The initial health evaluation shall include tuberculin testing in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

f) The licensee shall provide adequate, properly trained and supervised staff to meet each child's service plan.

g) The licensee shall designate a center manager.

h) There shall be at least one registered nurse at the center at all times that a child is present. At least one other staff person shall be present at the center at all times that a child is present.

i) The center shall have a medical director who is a physician with expertise in chronic diseases of children. The medical director shall have responsibilities for reviewing medical protocols, resolving issues with children's personal physicians and providing medical advice when a child's personal physician is not available.

j) The licensee shall define, through job descriptions, minimum education and experience requirements for all staff, consultants and contract staff providing services to the Children's Community-Based Health Care Center Model.

k) The licensee shall provide an initial orientation and routine, pertinent training to all staff. This training may include return demonstration, one-on-one training, small group exercises or lecture. All training shall be documented with:

1) date;

2) instructors;

3) short description of content; and

4) participants' written and printed signatures.

l) Prior to employing any individual in a position that requires a State license, the licensee shall contact the Illinois Department of Financial and Professional Regulation-Division of Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.

m) The licensee shall check the status of all applicants with the Nurse Aide Registry prior to hiring.

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.2300 Food Service

a) At least three meals a day shall be served. Every effort shall be made to meet dietary patterns that are routine to an individual child as described in the service plan.

b) Snacks shall be offered between meals and at bedtime.

c) If a child refuses the food served, reasonable and nutritionally appropriate substitutions shall be served.

d) Menus shall be planned at least one week in advance. All menus, as actually served, shall be kept on file for not less than 30 days.

e) Supplies of staple foods for a minimum of one week and of perishable foods for a minimum of two days shall be maintained on the premises.

f) All food served shall be prepared in accordance with the Department's rules entitled "Food Service Sanitation Code" (77 Ill. Adm. Code 750).

Section 260.2400 Physical Plant

a) Buildings shall meet the requirements established in the National Fire Protection Association Standard 101, Life Safety Code, 2000 edition, Chapter 23, "Existing Residential Board and Care Occupancies, Impractical", and other referenced chapter requirements.

b) Buildings shall be only one story in height, at grade level, or if a building has multiple stories, children shall be served only on the grade level story.

c) Children over six years of age occupying the same bedroom shall be of the same gender unless the children are siblings.

d) An individual shall not need to go through a child's bedroom to reach any other area of the building.

e) The center shall be kept in a clean, safe, and orderly condition and in good repair.

1) Electrical, mechanical, heating/air conditioning, fire protection and sewage disposal systems shall be maintained.

2) Furnishings and furniture shall be maintained in a clean, safe condition.

3) Attics, basements, stairways, and similar areas shall be kept free of accumulation of refuse, newspapers, boxes, and other items.

4) Bathtubs, shower stalls and lavatories shall not be used for janitorial, laundry or storage purposes.

5) All cleaning compounds, insecticides and other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms.

f) Every center shall have an effective means of supplying clean linen.

1) Clean linen shall be protected from contamination during handling, transport and storage.

2) Soiled linen shall be handled, transported and stored in a manner that protects individuals and the environment from contamination. Soiled diapers shall be placed in special diaper receptacles immediately after removal from the patient.

g) Each child shall be provided with a bed that meets his/her developmental needs and size.

h) The water supply shall comply with all applicable State codes and local ordinances. Each center shall be served by:

1) Water from a municipal water system; or

2) A water supply that complies with the Department's rules titled Drinking Water Systems Code (77 Ill. Adm. Code 900); or

3) A water supply that complies with the Department's rules titled Public Area Sanitary Practice Code (77 Ill. Adm. Code 895).

i) All sewage and liquid wastes shall be discharged into a public sewage disposal system or shall be collected, treated, and disposed of in a private sewage disposal system that is designed, constructed, maintained and operated in accordance with the Department's rules entitled Private Sewage Disposal Code (77 Ill. Adm. Code 905).

(Source: Amended at 31 Ill. Reg. 3008, effective February 2, 2007)

Section 260.2500 Quality Assessment and Improvement

a) The licensee shall develop and implement a quality assessment and improvement program designed to meet at least the following goals:

1) Ongoing monitoring and evaluation of the quality and accessibility of care and services provided at the facility or under contract, including but not limited to:

A) Admission of children appropriate to the capabilities of the facility;

B) Client satisfaction;

C) Costs for delivery of services; and

D) Infection control and safety.

2) Identification and analysis of problems.

3) Identification and implementation of corrective action or changes in response to problems.

b) The program shall operate pursuant to a written plan, which shall include, but not be limited to:

1) A detailed statement of its goals;

2) The methodology and criteria that will be used to meet each stated goal;

3) The action plans for addressing problems;

4) Procedures for evaluating the effectiveness of action plans and revising action plans to prevent reoccurrence of problems;

5) Procedures for documenting the activities of the program; and

6) Identification of the persons responsible for administering the program.

c) The licensee shall afford the Department and the Board access to any materials or documents generated pursuant to the facility's quality assessment and improvement program or that otherwise relate to client demand, utilization and satisfaction; cost effectiveness; financial viability of the facility; and access to services. Such information shall be used by the Department and the Board to evaluate and assess the facility in relation to the Demonstration Program.

APPENDIX C:

DATA TABLES

TABLES IA & IB: TRANSITIONAL & RESPITE CARE

*TABLE IA

What percentage of Transitional & Respite Care patients have the following technology needs (past three calendar years)			
Almost Home Kids (Chicago and Naperville)	2018	2017	2016
Ventilator	53.3%	40.5%	36%
Tracheostomy	71%	74%	56%
Peritoneal Dialysis	1.3%	0%	0%
Central Line	7.89%	6.76%	13%
Enteral Feeding	94.7%	96.6%	91%
Total Parental Nutrition (TPN)	1.97%	2%	10%
Urinary Catheter	12.5%	12.8%	6%
Ostomy	1.97%	0%	6%
Oxygen	84.9%	87.8%	74%
Almost Home Kids (Peoria)	2018	2017	2016
Ventilator	75%		
Tracheostomy	75%		
Peritoneal Dialysis	0%		
Central Line	7%		
Enteral Feeding	100%		
Total Parental Nutrition (TPN)	7%		
Urinary Catheter	7%		
Ostomy	0%		
Oxygen	100%		
Maryville Children's Healthcare Center	2018	2017	2016
Ventilator	56%	41%	25%
Tracheostomy	90%	75%	65%
Peritoneal Dialysis	0%	0%	0%
Central Line	2.5%	2.5%	0%
Enteral Feeding	98%	80%	75%

Total Parental Nutrition (TPN)	0%	0%	0%
Urinary Catheter	12%	24%	24%
Ostomy	2%	2%	<1%
Oxygen	88%	80%	75%

*Table IA illustrates percentages of usage for specific technological needs

**Per *Almost Home Kids Peoria*, all data is provided from 10/1/2018 thru 3/31/19

*TABLE IB

Yearly Utilization Rate of Licensed beds at the facilities:			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	65.7% (Chi & Nap)	76.3%	73.2%
Maryville Children's Healthcare Center	~ 87.5%	68.75%	
How many days of transitional care did you provide? (past three calendar years)			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	5,183 days (Chi & Nap) 466 days (Peoria)	5,995 days	5,734 days
Maryville Children's Healthcare Center	4,745 days	4,161 days	3,285 days
How many days of respite care did you provide? (past three calendar years)			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	265 days (Chi & Nap)	312 days	221 days
Maryville Children's Healthcare Center	42 days	52 days	47 days
How many days have you cared for through both transitional/respite care for children in DCFS custody or intact family services?			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	1,468 days (Chi & Nap) 81 (Peoria)	2,058 days	1,054 days
Maryville Children's Healthcare Center	3,285 days	1,460 days	730 days

How many days of medical day camp/weekend care did you provide? (past three calendar years)			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	0	0	0
Maryville Children's Healthcare Center	0	0	0

*Table IB illustrates utilization rates by looking at total days of care
**Per *Almost Home Kids Peoria*, all data is provided from 10/1/2018 thru 3/31/19

*Table IC

What is the number of incidents of non-emergent transfers to hospital(s)? (past three years):			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville) *Peoria*	12 8	16 -	12 -
Maryville Children's Healthcare Center	10	14	12
What is the number of incidents of emergency transfers to hospital(s)? (past three years):			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville) *Peoria*	57 6	40 -	63 -
Maryville Children's Healthcare Center	4	7	18

TABLES IIA, IIB, IIC & IID: PATIENT INFORMATION

*Table IIA

Almost Home Kids (Chicago/Naperville)						
	2018		2017		2016	
AGE OF PATIENTS	Transition (%)	Respite (%)	Transition (%)	Respite (%)	Transition (%)	Respite (%)
< 3 YEARS:	63.2	28.9	71	17.5	74.4	16.6
4 - 6 YEARS:	9.6	10.5	6.5	10	1.5	9.5
8 - 10 YEARS:	12.3	15.8	1.9	25	4.5	23.8
11 – 15 YEARS:	9.6	21.1	12	12.5	6.8	9.5
>16 YEARS:	5.3	23.7	8	35	12.8	40.5
Maryville						
	2018		2017		2016	
AGE OF PATIENTS	Transition (%)	Respite (%)	Transition (%)	Respite (%)	Transition (%)	Respite (%)
< 3 YEARS:	50	0	10	0	10	0
4 - 6 YEARS:	10	0	22	0	35	2
8 - 10 YEARS:	10	0	10	0	7	0
11 – 15 YEARS:	5	50	13	100	10	0
>16 YEARS:	25	50	45	0	38	98
Almost Home Kids (Peoria)						
	2018		2017		2016	
AGE OF PATIENTS	Transition (%)	Respite (%)	Transition (%)	Respite (%)	Transition (%)	Respite (%)
< 3 YEARS:	87.5	0	-	-	-	-
4 - 6 YEARS:	0	33.3	-	-	-	-
8 - 10 YEARS:	0	0	-	-	-	-
11 – 15 YEARS:	12.5	33.3	-	-	-	-
>16 YEARS:	0	33.3	-	-	-	-

**Per *Almost Home Kids Peoria*, all data is provided from 10/1/2018 thru 3/31/19

*Table IIB

Almost Home Kids (Chicago/Naperville)			
FINAL DISCHARGE SETTING	Transitional Care 2018 (%)	Transitional Care 2017 (%)	Transitional Care 2016 (%)
FAMILY MEMBER CARE/HOME:	88.3	92	91.7
LONG TERM CARE FACILITY/ SKILLED NURSING FACILITY (SNF):	4.7	5.5	4.2
FOSTER CARE:	-	-	-
HOSPICE:	0	2.5	2
OTHER (please specify):	6.97 Rehab.	0	0
Maryville			
FINAL DISCHARGE SETTING	Transitional Care 2018 (%)	Transitional Care 2017 (%)	Transitional Care 2016 (%)
FAMILY MEMBER CARE/HOME:	80	95	67
LONG TERM CARE FACILITY/ SKILLED NURSING FACILITY (SNF):	0	0	33.3
FOSTER CARE:	20	5	0
HOSPICE:	0	0	0
OTHER (please specify):			
Almost Home Kids (Peoria)			
FINAL DISCHARGE SETTING	Transitional Care 2018 (%)	Transitional Care 2017 (%)	Transitional Care 2016 (%)
FAMILY MEMBER CARE/HOME:	25	-	-
LONG TERM CARE FACILITY/ SKILLED NURSING FACILITY (SNF):	0	-	-
FOSTER CARE:	0	-	-
HOSPICE:	0	-	-
OTHER (please specify):	75 (Childrens hospital)	-	-

**Per *Almost Home Kids Peoria*, all data is provided from 10/1/2018 thru 3/31/19

*Table IIC

What is the percentage of families you serve who don't speak English as their primary language? (past three calendar years)			
Facility	2018	2017	2016
Almost Home Kids facilities (CHI, Naperville, Peoria)	~ 18 % 12.5 % (Peoria)**	~ 11 %	~25 %
Maryville Children's Healthcare Center	2 %	2 %	1 %

*Table IIC illustrates language barriers. Maryville and Almost Home provides Spanish translators onsite.
**Almost *Home Kids Peoria* has used translation services for Chin-Haka (A Burmese dialect)

TABLE III: FIANANCIAL OPERATING INFORMATION

*Table III

Maryville Financial Information			
Special Revenue Items	FY18	FY17	FY16
Contributions, Gifts, Grants and Other	$3,426,000	$1,837,000	$1,925,000
Net Income from Events	$364,000	$478,000	$491,000
Total Revenue	$3,790,000	$2,315,000	$2,416,000

Almost Home Kids (Chicago & Naperville)			
Special Revenue Items	FY18	FY17	FY16
Contributions, Gifts, Grants and Other	$4,186,230	$4,175,112	$4,244,980
Net Income from Events	$1,913,630	$1,731,834	$729,678
Total Revenue	$6,099,860	$5,906,946	$4,974,658
Advertising Expenses	FY18	FY17	FY16
TV Advertising	-	-	-
Radio Advertising	-	-	-
Print Advertising	-	-	-
Social Media Advertising	-	-	-
Other Advertising: (please list)	$109,295**	$115,484**	$103,783**

Almost Home Kids (Peoria)			
Special Revenue Items	FY18	FY17	FY16
Contributions, Gifts, Grants and Other	$60,000	-	-
Net Income from Events	$44,000	-	-
Total Revenue	$104,000	-	-
Advertising Expenses	FY18	FY17	FY16
TV Advertising	0	-	-
Radio Advertising	$2,006	-	-
Print Advertising	$9,819	-	-
Social Media Advertising	$3,295	-	-
Other Advertising: (please list)	-	-	-

*Maryville does not utilize any advertising for their facility
** Almost Home does not divide up their advertising totals