The House Special Committee on Access to Quality Health Care offers the following substitute to HB 198:

A BILL TO BE ENTITLED
AN ACT

To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to revise and provide for definitions relative to health planning and development; to eliminate the requirement that certain expenditures by a health care facility are required to obtain a certificate of need; to eliminate the Health Strategies Council; to provide for the conversion of destination cancer hospitals; to provide certain indigent and charity care requirements; to provide for penalties; to require certain facilities to participate as Medicaid providers; to provide limitations on opposing an application; to provide for additional exemptions from certificate of need requirements; to provide for the submission of certain documents to the Department of Community Health and the posting of certain documents on hospital websites; to prohibit certain actions relating to medical use rights; to provide for the investment of funds by hospital authorities; to amend Code Section 48-7-29.20 of the Official Code of Georgia Annotated, relating to tax credits for contributions to rural hospital organizations, so as to revise provisions relating to the rural hospital tax credit program; to revise Code Section 50-18-70 of the Official Code of Georgia Annotated, relating to legislative intent and definitions relative to open records laws, so as to revise definitions; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I
SECTION 1-1.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by revising paragraphs (8), (14), (17), (19), (21), (23), and (33) of and by adding a new paragraph to Code Section 31-6-2, relating to definitions relative to state health planning and development, as follows:

"(8) 'Clinical health services' means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are
located in a health care facility, and includes, but is not limited to, the following:

radiology and diagnostic imaging, such as magnetic resonance imaging and positron
emission tomography (PET); radiation therapy; biliary lithotripsy; surgery; intensive care;
coronary care; pediatrics; gynecology; obstetrics; general medical care; medical/surgical
care; inpatient nursing care, whether intermediate, skilled, or extended care; cardiac
catheterization; open-heart surgery; and inpatient rehabilitation; and alcohol, drug abuse;
and mental health services."

'(14) 'Develop,' with reference to a project, means:

(A) Constructing, remodeling, installing, or proceeding with a project, or any part of
a project, or a capital expenditure project, the cost estimate for which exceeds $2.5
million $10 million; or

(B) The expenditure or commitment of funds exceeding $4 million for
orders, purchases, leases, or acquisitions through other comparable arrangements of
major medical equipment; provided, however, that this shall not include build-out costs,
as defined by the department, but shall include all functionally related equipment,
software, and any warranty and services contract costs for the first five years.
Notwithstanding subparagraphs (A) and (B) of this paragraph, the expenditure or
commitment or incurring an obligation for the expenditure of funds to develop certificate
of need applications, studies, reports, schematics, preliminary plans and specifications,
or working drawings or to acquire, develop, or prepare sites shall not be considered to be
the developing of a project."

'(16.1) 'Freestanding emergency department' means a facility that provides emergency
services, but that is structurally separate and distinct from a hospital and has no more than
one inpatient bed and that:

(A) Is operated pursuant to a hospital's license and located within 35 miles of such
hospital;

(B) Is subject to the federal 'Emergency Medical Treatment and Labor Act';

(C) Operates 24 hours per day, 365 days per year; and

(D) Is a Medicaid provider and treats Medicaid recipients.

(17) 'Health care facility' means hospitals; destination cancer hospitals; other special care
units, including but not limited to podiatric facilities; skilled nursing facilities;
intermediate care facilities; personal care homes; ambulatory surgical centers or
obstetrical facilities; freestanding emergency departments; health maintenance
organizations; home health agencies; and diagnostic, treatment, or rehabilitation centers,
but only to the extent paragraph (3) or (7), or both paragraphs (3) and (7), of subsection
(a) of Code Section 31-6-40 are applicable thereto."
"(19) 'Health Strategies Council' or 'council' means the body created by this chapter to advise the department. Reserved."

"(21) 'Hospital' means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, psychiatric, rehabilitative, geriatric, osteopathic, micro-hospitals, and other specialty hospitals."

"(23) 'Joint venture ambulatory surgical center' means a freestanding ambulatory surgical center that is jointly owned by a hospital in the same county as the center or a hospital in a contiguous county if there is no hospital in the same county as the center and a single group of physicians practicing in the center and that provides surgery or where cardiologists perform procedures in a single specialty as defined by the department; provided, however, that general surgery, a group practice which includes one or more psychiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty. The ownership interest of the hospital shall be no less than 30 percent and the collective ownership of the physicians or group of physicians shall be no less than 30 percent."

"(33) 'Single specialty ambulatory surgical center' means an ambulatory surgical center where surgery is performed or where cardiologists perform procedures in the offices of an individual private physician or single group practice of private physicians if such surgery or cardiology procedures are is performed in a facility that is owned, operated, and utilized by such physicians who also are of a single specialty; provided, however, that general surgery, a group practice which includes one or more psychiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty."

SECTION 1-2.

Said title is further amended by revising paragraphs (3) and (8) of subsection (b) of Code 31-6-21, relating to the Department of Community Health generally, as follows:

"(3) To seek advice, at its discretion, from the Health Strategies Council in the performance by the department of its functions pursuant to this chapter. Reserved."
"(8) To establish, by rule, need methodologies for new institutional health services and health facilities. In developing such need methodologies, the department shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, financial and geographic accessibility, and market economics. The department shall establish service-specific need methodologies and criteria for at least the following clinical health services: short stay hospital beds, adult therapeutic cardiac catheterization, adult open heart surgery, pediatric cardiac catheterization and open heart surgery, Level II and III perinatal services, freestanding birthing centers, psychiatric and substance abuse inpatient programs, skilled nursing and intermediate care facilities, home health agencies, and continuing care retirement community sheltered facilities;"

**SECTION 1-3.**

Said title is further amended by revising subsection (a) of and by adding a new subsection to Code Section 31-6-40, relating to the requirement of a certificate of need for new institutional health services and exemption, as follows:

"(a) On and after July 1, 2008, any new institutional health service shall be required to obtain a certificate of need pursuant to this chapter. New institutional health services include:

(1) The construction, development, or other establishment of a new health care facility;

(2) Any expenditure by or on behalf of a health care facility in excess of $2.5 million which, under generally accepted accounting principles consistently applied, is a capital expenditure, except expenditures for acquisition of an existing health care facility not owned or operated by or on behalf of a political subdivision of this state, or any combination of such political subdivisions, or by or on behalf of a hospital authority, as defined in Article 4 of Chapter 7 of this title, or certificate of need owned by such facility in connection with its acquisition. The dollar amounts specified in this paragraph and in subparagraph (A) of paragraph (14) of Code Section 31-6-2 shall be adjusted annually by an amount calculated by multiplying such dollar amounts (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph and subparagraph (A) of paragraph (14) of Code Section 31-6-2, the costs of all items subject to review by this chapter and items not subject to
review by this chapter associated with and simultaneously developed or proposed with
the project shall be counted, except for the expenditure or commitment of or incurring an
obligation for the expenditure of funds to develop certificate of need applications, studies,
reports, schematics, preliminary plans and specifications or working drawings, or to
acquire sites;
(3) The purchase or lease by or on behalf of a health care facility or a diagnostic,
treatment, or rehabilitation center of diagnostic or therapeutic equipment with a value in
excess of $1 million; provided, however, that diagnostic or other imaging
services that are not offered in a hospital or in the offices of an individual private
physician or single group practice of physicians exclusively for use on patients of that
physician or group practice shall be deemed to be a new institutional health service
regardless of the cost of equipment; and provided, further, that this shall not include build
out costs, as defined by the department, but shall include all functionally related
equipment, software, and any warranty and services contract costs for the first five years.
The acquisition of one or more items of functionally related diagnostic or therapeutic
equipment shall be considered as one project. The dollar amount specified in this
paragraph, in subparagraph (B) of paragraph (14) of Code Section 31-6-2, and in
paragraph (10) of subsection (a) of Code Section 31-6-47 shall be adjusted annually by
an amount calculated by multiplying such dollar amounts (as adjusted for the preceding
year) by the annual percentage of change in the consumer price index, or its successor or
appropriate replacement index, if any, published by the United States Department of
Labor for the preceding calendar year, commencing on July 1, 2010;
(4) Any increase in the bed capacity of a health care facility except as provided in Code
Section 31-6-47;
(5) Clinical health services which are offered in or through a health care facility, which
were not offered on a regular basis in or through such health care facility within the 12
month period prior to the time such services would be offered;
(6) Any conversion or upgrading of any general acute care hospital to a specialty hospital
or of a facility such that it is converted from a type of facility not covered by this chapter
to any of the types of health care facilities which are covered by this chapter; and
(7) Clinical health services which are offered in or through a diagnostic, treatment, or
rehabilitation center which were not offered on a regular basis in or through that center
within the 12 month period prior to the time such services would be offered, but only if
the clinical health services are any of the following:
   (A) Radiation therapy;
   (B) Biliary lithotripsy;
(C) Surgery in an operating room environment, including but not limited to ambulatory surgery; and

(D) Cardiac catheterization."

“(d.1) A destination cancer hospital that was granted a certificate of need prior to July 1, 2019, may convert to a hospital without obtaining any additional certificate of need by notifying the department in writing as to the date of conversion. Upon such conversion, such hospital may continue to provide all institutional health services and other services it provided as of the date of such conversion, including but not limited to inpatient beds, outpatient services, surgery, radiation therapy, imaging, and positron emission tomography (PET) scanning without any further approval from the department. On and after such conversion the hospital shall not be subject to paragraph (13) of Code Section 31-6-2, subsection (d) of this Code section, subsection (c.1) of Code Section 31-6-40.1, the provisions specifically applicable to provisions or regulations applicable to destination cancer hospitals contained in subsection (c) of Code Section 31-6-40.1, paragraph (7) of subsection (a) of Code Section 31-6-45, or any other destination cancer hospitals; provided, however, that upon such conversion, the hospital shall be required to provide uncompensated indigent or charity care in accordance with subsection (c) of Code Section 31-6-40.1, and shall be classified as a hospital under this chapter and shall be subject to all requirements and conditions for any new institutional health services, exemptions, and all other purposes.”

SECTION 1-4.

Said title is further amended by revising subsection (c) of Code Section 31-6-40.1, relating to acquisition of health care facilities, penalty for failure to notify the department, limitation on applications, agreement to care for indigent patients, requirements for destination cancer hospitals, and notice and hearing provisions for penalties authorized under this Code section, as follows:

“(c) Except as otherwise provided by Code Section 31-6-40.3, the department may require that any applicant for a certificate of need agree to provide a specified amount of clinical health services to indigent patients as a condition for the grant of a certificate of need; provided, however, that each facility granted a certificate of need by the department as a destination cancer hospital shall be required to provide uncompensated indigent or charity care for residents of Georgia which meets or exceeds 3 percent of such destination cancer hospital’s adjusted gross revenues and provide care to Medicaid beneficiaries. A grantee or successor in interest of a certificate of need or an authorization to operate under this chapter which violates such an agreement or violates any conditions imposed by the department relating to such services, whether made before or after July 1, 2008, shall be
liable to the department for a monetary penalty in the amount of the difference between the
amount of services so agreed to be provided and the amount actually provided and may be
subject to revocation of its certificate of need, in whole or in part, by the department
pursuant to Code Section 31-6-45. Any penalty so recovered shall be paid into the state
treasury. On and after June 30, 2019, each certificate of need holder and each exemption
holder subject to indigent and charity care requirements shall report to the department
uncompensated indigent and charity care based on the Medicare base allowable rate for the
unpaid service provided multiplied by a factor of 1.5, and not based on the hospital's charge
for such services; provided, however, that such calculation shall not count against any such
certificate of need holder and each exemption holder subject to indigent and charity care
requirements prior to June 30, 2021."

SECTION 1-5.

Said title is further amended by adding new Code sections to read as follows:

"31-6-40.3.

(a) On and after July 1, 2021, the department shall require that an applicant and any
licensee that makes a modification to its certificate of need agrees:

(1) To provide uncompensated indigent or charity care in an amount which meets or
exceeds the percentage of such applicant's adjusted gross revenues equivalent to:

(A) The state-wide average of net uncompensated indigent and charity care provided
based on the previous two most recent years if a nonprofit entity; provided, however,
that in no event shall this be less than 2 percent; or

(B) The state-wide average of net uncompensated indigent and charity care provided
based on the previous two most recent years less 3 percent if a for profit entity;
provided, however, that in no event shall this be less than 1 percent; and

(2) To participate as a provider of medical assistance for Medicaid purposes, and, if the
facility provides medical care and treatment to children, to participate as a provider for
PeachCare for Kids beneficiaries.

(a.1) For purposes of calculating uncompensated indigent or charity care pursuant to this
Code section, uncompensated indigent or charity care provided by a physician, who has an
ownership interest in an ambulatory surgical center, to a patient in a hospital or other
setting outside such ambulatory surgical center shall be counted toward the uncompensated
indigent or charity care required for the ambulatory surgical center in which the physician
has an ownership interest in an amount equal to the cost of such care provided multiplied
by the percentage ownership of the physician and shall not be counted toward the
uncompensated indigent or charity care required for a hospital or other setting.
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(b) A grantee or successor in interest for a certificate of need or an exemption under this chapter that violates such an agreement or violates any conditions imposed by the department relating to such services shall be liable to the department for a monetary penalty in the amount of 1.0 percent of its net revenue for every 0.5 percent of uncompensated indigent and charity care not provided and may be subject to revocation of its certificate of need or exemption, in whole or in part, by the department pursuant to Code Section 31-6-45. Any penalty so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state.

(c) Penalties authorized under this Code section shall be subject to the same notices and hearing for the levy of fines under Code Section 31-6-45.

(d)(1) This Code section shall not apply to a hospital or any health care facilities owned by a hospital or health care system that:

(A) Has a payer mix of greater than 40 percent Medicaid recipients and uncompensated indigent and charity care of at least 2 percent; provided, however, that a hospital's cost gap between its Medicaid reimbursement rate and the Medicare reimbursement shall count toward such uncompensated indigent and charity care amount; or

(B) Has an inpatient population of catastrophic injury patients that exceeds 60 percent of total inpatients treated annually.

(2) As used in this subsection, the term:

(A) 'Catastrophic injury' means an injury to the spinal cord, an acquired brain injury, and other paralyzing neuromuscular conditions.

(B) 'Payer mix' means the proportionate share of itemized charges attributable to patients assignable to a specific payer classification to total itemized charges for all patients.

(e) The department may withhold all or any portion of disproportionate share of hospital funds to any hospital that is subject to the requirements contained in paragraph (1) of subsection (a) of this Code section that fails to meet the minimum indigent and charity care requirements for two consecutive years.

(f) For purposes of this Code section, uncompensated indigent and charity care shall be based on the Medicare base allowable rate for the unpaid service provided multiplied by a factor of 1.5, and shall not be based on the hospital's charge for such services.
(g) A certificate of need holder or exemption holder may include up to 15 percent of its Medicaid payments toward the uncompensated indigent and charity care amounts required of it pursuant to this Code section.

(h) A rural hospital organization that is ranked by the department in the top 25 eligible rural hospital organizations in financial need pursuant to paragraph (1) of subsection (b) of Code Section 31-8-9.1 shall be exempt from this Code section so long as it continues to be ranked as such.

31-6-40.4.

(a) On and after January 1, 2020, a destination cancer hospital may convert to a hospital by notifying the department in writing as to the date of conversion. Upon such conversion, the hospital may continue to provide all institutional health services and other services it provided as of the date of such conversion, including but not limited to inpatient beds, outpatient services, surgery, radiation therapy, imaging, and positron emission tomography (PET) scanning, without any further approval from the department; provided, that it provides uncompensated indigent or charity care in accordance with subsection (c) of Code Section 31-6-40.1 and Code Section 31-6-40.3. On and after the date of conversion, the hospital shall be classified as a hospital under this chapter and shall be subject to all requirements and conditions applicable to hospitals under this article.

(b) Upon conversion to a hospital, the facility's inpatient beds, operating rooms, radiation therapy equipment, and imaging equipment shall not be counted in the inventory by the department for purposes of determining need for additional providers except that any inpatient beds, operating rooms, radiation therapy equipment, and imaging equipment added after the date of conversion shall be counted.

(c) In the event that a destination cancer hospital does not convert to a hospital, it shall remain subject to all requirements and conditions applicable to destination cancer hospitals under this article."

SECTION 1-6.

Said title is further amended in Code Section 31-6-43, relating to acceptance or rejection of application for certificate, by revising subsections (d) and (h) as follows:

"(d)(1) There shall be a time limit of 120 days for review of a project, beginning on the day the department declares the application complete for review or in the case of applications joined for comparative review, beginning on the day the department declares the final application complete. The department may adopt rules for determining when it is not practicable to complete a review in 120 days and may extend the review period upon written notice to the applicant but only for an extended period of not longer than an
additional 30 days. The department shall adopt rules governing the submission of
additional information by the applicant and for opposing an application.

(2) No party may oppose an application for a certificate of need for a proposed project
unless such party is an existing health care facility that is the same type of facility
proposed or which offers substantially similar services proposed that is located within a
35 mile radius of the proposed project.”

“(h) The department shall provide the applicant an opportunity to meet with the department
to discuss the application and to provide an opportunity to submit additional information.
Such additional information shall be submitted within the time limits adopted by the
department. The department shall also provide an opportunity for any party that is opposed
to permitted to oppose an application pursuant to paragraph (2) of subsection (d) of this
Code section to meet with the department and to provide additional information to the
department. In order for an any such opposing party to have standing to appeal an adverse
decision pursuant to Code Section 31-6-44, such party must attend and participate in an
opposition meeting.”

SECTION 1-7.

Said title is further amended in Code Section 31-6-44, relating to the Certificate of Need
Appeal Panel, by revising subsections (a) and (d) as follows:

“(a) Effective July 1, 2008, there is created the Certificate of Need Appeal Panel, which
shall be an agency separate and apart from the department and shall consist of a panel of
independent hearing officers. The purpose of the appeal panel shall be to serve as a panel
of independent hearing officers to review the department's initial decision to grant or deny
a certificate of need application. The Health Planning Review Board which existed on June
30, 2008, shall cease to exist after that date and the Certificate of Need Appeal Panel shall
be constituted effective July 1, 2008, pursuant to this Code section. The terms of all
members of the Health Planning Review Board serving as such on June 30, 2008, shall
automatically terminate on such date.”

“(d) Any applicant for a project, any competing applicant in the same batching cycle, any
competing health care facility party that is permitted to oppose an application pursuant to
paragraph (2) of subsection (d) of Code Section 31-6-43 that has notified the department
prior to its decision that such facility party is opposed to the application before the
department, or any county or municipal government in whose boundaries the proposed
project will be located who is aggrieved by a decision of the department shall have the right
to an initial administrative appeal hearing before an appeal panel hearing officer or to
intervene in such hearing. Such request for hearing or intervention shall be filed with the
chairperson of the appeal panel within 30 days of the date of the decision made pursuant
to Code Section 31-6-43. In the event an appeal is filed by a competing applicant, or any competing health care facility, or any county or municipal government party that is permitted to oppose an application pursuant to paragraph (2) of subsection (d) of Code Section 31-6-43, the appeal shall be accompanied by payment of such fee as is established by the appeal panel. In the event an appeal is requested, the chairperson of the appeal panel shall appoint a hearing officer for each such hearing within 30 days after the date the appeal is received. Within 14 days after the appointment of the hearing officer, such hearing officer shall confer with the parties and set the date or dates for the hearing, provided that no hearing shall be scheduled less than 60 days nor more than 120 days after the filing of the request for a hearing, unless the applicant consents or, in the case of competing applicants, all applicants consent to an extension of this time period to a specified date. Unless the applicant consents or, in the case of competing applicants, all applicants consent to an extension of said 120 day period, any hearing officer who regularly fails to commence a hearing within the required time period shall not be eligible for continued service as a hearing officer for the purposes of this Code section. The hearing officer shall have the authority to dispose of all motions made by any party before the issuance of the hearing officer's decision and shall make such rulings as may be required for the conduct of the hearing.”

SECTION 1-8.

Said title is further amended by adding a new Code section to read as follows:

“31-6-45.3.

No freestanding emergency facility shall be permitted in this state unless it meets the criteria contained in paragraph (16.1) of Code Section 31-6-2.”

SECTION 1-9.

Said title is further amended by revising Code Section 31-6-47, relating to exemptions from certificate of need program requirements, as follows:

“31-6-47.

(a) Notwithstanding the other provisions of this chapter, this chapter shall not apply to:

(1) Infirmaries operated by educational institutions for the sole and exclusive benefit of students, faculty members, officers, or employees thereof;

(2) Infirmaries or facilities operated by businesses for the sole and exclusive benefit of officers or employees thereof, provided that such infirmaries or facilities make no provision for overnight stay by persons receiving their services;

(3) Institutions operated exclusively by the federal government or by any of its agencies;
(4) Offices of private physicians or dentists whether for individual or group practice, except as otherwise provided in paragraph (3) or (7) of subsection (a) of Code Section 31-6-40;

(5) Religious, nonmedical health care institutions as defined in 42 U.S.C. § 1395x(ss)(1), listed and certified by a national accrediting organization;

(6) Site acquisitions for health care facilities or preparation or development costs for such sites prior to the decision to file a certificate of need application;

(7) Expenditures related to adequate preparation and development of an application for a certificate of need;

(8) The commitment of funds conditioned upon the obtaining of a certificate of need;

(9) Expenditures for the acquisition of existing health care facilities by stock or asset purchase, merger, consolidation, or other lawful means unless the facilities are owned or operated by or on behalf of a:

(A) Political subdivision of this state;

(B) Combination of such political subdivisions; or

(C) Hospital authority, as defined in Article 4 of Chapter 7 of this title;

(9.1) Expenditures for the restructuring of or for the acquisition by stock or asset purchase, merger, consolidation, or other lawful means of an existing health care facility which is owned or operated by or on behalf of any entity described in subparagraph (A), (B), or (C) of paragraph (9) of this subsection only if such restructuring or acquisition is made by any entity described in subparagraph (A), (B), or (C) of paragraph (9) of this subsection;

(9.2) The purchase of a closing hospital or of a hospital that has been closed for no more than 12 months by a hospital in a contiguous county to repurpose the facility as a micro-hospital;

(10) Expenditures of less than $870,000.00 for any minor or major repair or replacement of equipment by a health care facility that is not owned by a group practice of physicians or a hospital and that provides diagnostic imaging services if such facility received a letter of nonreviewability from the department prior to July 1, 2008. This paragraph shall not apply to such facilities in rural counties;

(10.1) Except as provided in paragraph (10) of this subsection, expenditures for the minor or major repair of a health care facility or a facility that is exempt from the requirements of this chapter, parts thereof or services provided or equipment used therein; or the replacement of equipment, including but not limited to CT scanners previously approved for a certificate of need;

(11) Capital expenditures otherwise covered by this chapter required solely to eliminate or prevent safety hazards as defined by federal, state, or local fire, building,
environmental, occupational health, or life safety codes or regulations, to comply with licensing requirements of the department, or to comply with accreditation standards of a nationally recognized health care accreditation body;

(12) Cost overruns whose percentage of the cost of a project is equal to or less than the cumulative annual rate of increase in the composite construction index, published by the Bureau of the Census of the Department of Commerce, of the United States government, calculated from the date of approval of the project;

(13) Transfers from one health care facility to another such facility of major medical equipment previously approved under or exempted from certificate of need review, except where such transfer results in the institution of a new clinical health service for which a certificate of need is required in the facility acquiring said equipment, provided that such transfers are recorded at net book value of the medical equipment as recorded on the books of the transferring facility;

(14) New institutional health services provided by or on behalf of health maintenance organizations or related health care facilities in circumstances defined by the department pursuant to federal law;

(15) Increases in the bed capacity of a hospital up to ten beds or 20 percent of capacity, whichever is greater, in any consecutive two-year period, in a hospital that has maintained an overall occupancy rate greater than 60 percent for the previous 12 month period;

(16) Expenditures for nonclinical projects, including parking lots, parking decks, and other parking facilities; computer systems, software, and other information technology; and medical office buildings; and state mental health facilities;

(17) Continuing care retirement communities, provided that the skilled nursing component of the facility is for the exclusive primary use of residents of the continuing care retirement community and that a written exemption is obtained from the department; provided, however, that new sheltered nursing home beds may be used on a limited basis by persons who are not residents of the continuing care retirement community for a period up to five years after the date of issuance of the initial nursing home license, but such beds shall not be eligible for Medicaid reimbursement. For the first year, the continuing care retirement community sheltered nursing facility may utilize not more than 50 percent of its licensed beds for patients who are not residents of the continuing care retirement community. In the second year of operation, the continuing care retirement community shall allow not more than 40 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. In the third year of operation, the continuing care retirement community shall allow not more than 30 percent of its licensed beds for new patients who are not residents of the continuing care retirement community.
care retirement community. In the fourth year of operation, the continuing care retirement community shall allow not more than 20 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. In the fifth year of operation, the continuing care retirement community shall allow not more than 10 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. At no time during the first five years shall the continuing care retirement community sheltered nursing facility occupy more than 50 percent of its licensed beds with patients who are not residents under contract with the continuing care retirement community. At the end of the five-year period, the continuing care retirement community sheltered nursing facility shall be utilized exclusively by residents of the continuing care retirement community, and at no time shall a resident of a continuing care retirement community be denied access to the sheltered nursing facility. At no time shall any existing patient be forced to leave the continuing care retirement community to comply with this paragraph. The department is authorized to promulgate rules and regulations regarding the use and definition of 'sheltered nursing facility' in a manner consistent with this Code section. Agreements to provide continuing care include agreements to provide care for any duration, including agreements that are terminable by either party;

(18) Any single specialty ambulatory surgical center that:

(A)(i) Has capital expenditures associated with the construction, development, or other establishment of the clinical health service which do not exceed $2.5 million; or

(ii) Is the only single specialty ambulatory surgical center in the county owned by the group practice and has two or fewer operating rooms; provided, however, that a center exempt pursuant to this division shall be required to obtain a certificate of need in order to add any additional operating rooms;

(B) Has a hospital affiliation agreement with a hospital within a reasonable distance from the facility or the medical staff at the center has admitting privileges or other acceptable documented arrangements with such hospital to ensure the necessary backup for the center for medical complications. The center shall have the capability to transfer a patient immediately to a hospital within a reasonable distance from the facility with adequate emergency room services. Hospitals shall not unreasonably deny a transfer agreement or affiliation agreement to the center;

(C)(i) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in an amount equal to or greater than 2 percent of its adjusted gross revenue; or
(ii) If the center is not a participant in Medicaid or the PeachCare for Kids Program, provides uncompensated care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries, uncompensated indigent and charity care, or both in an amount equal to or greater than 4 percent of its adjusted gross revenue; provided, however, that single specialty ambulatory surgical centers owned by physicians in the practice of ophthalmology shall not be required to comply with this subparagraph; and

(D) Provides annual reports in the same manner and in accordance with Code Section 31-6-70.

Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6-70 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by multiplying such dollar amount (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites;

(19) Any joint venture ambulatory surgical center that:

(A) Has capital expenditures associated with the construction, development, or other establishment of the clinical health service which do not exceed $5 million;

(B)(i) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in an amount equal to or greater than 2 percent of its adjusted gross revenue; or
(ii) If the center is not a participant in Medicaid or the PeachCare for Kids Program, provides uncompensated care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries, uncompensated indigent and charity care, or both in an amount equal to or greater than 4 percent of its adjusted gross revenue; and

(C) Provides annual reports in the same manner and in accordance with Code Section 31-6-70.

Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6-70 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by multiplying such dollar amount (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites;

(20) Expansion of services by an imaging center based on a population needs methodology taking into consideration whether the population residing in the area served by the imaging center has a need for expanded services, as determined by the department in accordance with its rules and regulations, if such imaging center:

(A) Was in existence and operational in this state on January 1, 2008;

(B) Is owned by a hospital or by a physician or a group of physicians comprising at least 80 percent ownership who are currently board certified in radiology;

(C) Provides three or more diagnostic and other imaging services;

(D) Accepts all patients regardless of ability to pay; and
(E) Provides uncompensated indigent and charity care in an amount equal to or greater than the amount of such care provided by the geographically closest general acute care hospital; provided, however, this paragraph shall not apply to an imaging center in a rural county;

(21) Diagnostic cardiac catheterization in a hospital setting on patients 15 years of age and older;

(22) Therapeutic cardiac catheterization in hospitals selected by the department prior to July 1, 2008, to participate in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) Study and therapeutic cardiac catheterization in hospitals that, as determined by the department on an annual basis, meet the criteria to participate in the C-PORT Study but have not been selected for participation; provided, however, that if the criteria requires a transfer agreement to another hospital, no hospital shall unreasonably deny a transfer agreement to another hospital;

(23) Infirmaries or facilities operated by, on behalf of, or under contract with the Department of Corrections or the Department of Juvenile Justice for the sole and exclusive purpose of providing health care services in a secure environment to prisoners within a penal institution, penitentiary, prison, detention center, or other secure correctional institution, including correctional institutions operated by private entities in this state which house inmates under the Department of Corrections or the Department of Juvenile Justice;

(24) The relocation of any skilled nursing facility, intermediate care facility, or micro-hospital within the same county, any other health care facility in a rural county within the same county, and any other health care facility in an urban county within a three-mile radius of the existing facility so long as the facility does not propose to offer any new or expanded clinical health services at the new location;

(25) Facilities which are devoted to the provision of treatment and rehabilitative care for periods continuing for 24 hours or longer for persons who have traumatic brain injury, as defined in Code Section 37-3-1; and

(26) Capital expenditures for a project otherwise requiring a certificate of need if those expenditures are for a project to remodel, renovate, replace, or any combination thereof, a medical-surgical hospital and:

(A) That hospital:

(i) Has a bed capacity of not more than 50 beds;

(ii) Is located in a county in which no other medical-surgical hospital is located;

(iii) Has at any time been designated as a disproportionate share hospital by the department; and
(iv) Has at least 45 percent of its patient revenues derived from Medicare, Medicaid, or any combination thereof, for the immediately preceding three years; and

(B) That project:

(i) Does not result in any of the following:

(I) The offering of any new clinical health services;

(II) Any increase in bed capacity;

(III) Any redistribution of existing beds among existing clinical health services; or

(IV) Any increase in capacity of existing clinical health services;

(ii) Has at least 80 percent of its capital expenditures financed by the proceeds of a special purpose county sales and use tax imposed pursuant to Article 3 of Chapter 8 of Title 48; and

(iii) Is located within a three-mile radius of and within the same county as the hospital's existing facility.

(27) Public or private psychiatric hospitals, mental health or substance abuse facilities or programs, or mental health or substance abuse services; and

(28) A freestanding ambulatory surgical center with no more than six operating rooms developed on the same site as a sports training and educational facility that includes sports training facilities and fields; a medical education facility and program for physicians and other health care professionals training in sports medicine; a medical research program; ancillary services, including physical therapy and diagnostic imaging; a community education program for student athletic programs on injury prevention and treatment and related topics, and that provides uncompensated indigent or charity care in accordance with subsection (c) of Code Section 31-6-40.1 and Code Section 31-6-40.3, provides care to Medicaid patients, and demonstrates a positive economic impact of no less than $25 million, taking into consideration the full-time and part-time jobs generated by the initial construction and ongoing operation of the center, new state and local tax revenue generated by the initial construction and ongoing operation of the center, and other factors deemed relevant as determined by the department based on a report prepared by an independent consultant or expert retained by the center.

(b) By rule, the department shall establish a procedure for expediting or waiving reviews of certain projects the nonreview of which it deems compatible with the purposes of this chapter, in addition to expenditures exempted from review by this Code section.”
Said title is further amended by adding new Code sections to Article 1 of Chapter 7, relating to regulation of hospitals and related institutions, to read as follows:

"31-7-22.
(a) As used in this Code section, the term 'hospital' means a nonprofit hospital, a hospital owned or operated by a hospital authority, or a nonprofit corporation formed, created, or operated by or on behalf of a hospital authority.
(b) Beginning July 1, 2020, each hospital in this state shall post a link in a prominent location on the main page of its website to the most recent version of the following documents:
   (1) Federal related disclosures:
      (A) Copies of audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital; each of its affiliates, except those affiliates that were inactive or that had an immaterial amount of total assets; and the hospital's parent corporation that include the following:
         (i) A PDF version of all audited financial statements;
         (ii) A note in the hospital's audited consolidated financial statements that identifies individual amounts for such hospital's gross patient revenue, allowances, charity care, and net patient revenue;
         (iii) Audited consolidated financial statements for hospitals with subsidiaries and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each subsidiary's numbers with a report from independent accountants on other financial information; and
         (iv) Audited consolidated financial statements for the hospital's parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each affiliate's numbers with a report from independent accountants on other financial information; and
      (B) Copy of audited Internal Revenue Service Form 990, including Schedule H for hospitals and other applicable attachments; provided, however, that for any hospital not required to file IRS Form 990, the department shall establish and provide a form that collects the same information as is contained in Internal Revenue Service Form 990, including Schedule H for hospitals, as applicable; and

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(2) Georgia supplemental disclosures:

(A) Copy of the hospital's completed annual hospital questionnaire, as required by the department;

(B) The community benefit report prepared pursuant to Code Section 31-7-90.1, if applicable;

(C) The disproportionate share hospital survey, if applicable;

(D) Listing of all property holdings of the hospital, including the location and size, parcel ID number, purchase price, current use, and any improvements made to such property at the end of each fiscal year;

(E) Listing of any ownership or interest the nonprofit hospital has in any joint venture, business venture foundation, operating contract, partnership, subsidiary holding company, or captive insurance company; where any such entity is domiciled; and the value of any such ownership or interest at the end of each fiscal year;

(F) Listing of any bonded indebtedness, outstanding loans, and bond defaults, whether or not in forbearance; and any bond disclosure sites of the hospital;

(G) A report that identifies by purpose, the ending fund balances of the net assets of the hospital and each affiliate as of the close of the most recently completed fiscal year, distinguishing between donor permanently restricted, donor temporarily restricted, board restricted, and unrestricted fund balances. The hospital's interest in its foundation shall be deducted from the foundation's total fund balance;

(H) Report of all cash reserves of the hospital;

(I) Copy of all going concern statements regarding the hospital;

(J) The most recent legal chart of corporate structure, including the hospital, each of its affiliates and subsidiaries, and its parent corporation, duly dated;

(K) Report listing the salaries and fringe benefits for the ten highest paid administrative positions in the hospital. Each position shall be identified by its complete, unabbreviated title. Fringe benefits shall include all forms of compensation, whether actual or deferred, made to or on behalf of the employee, whether full or part-time;

(L) Evidence of accreditation by accrediting bodies, including, but not limited to, the Joint Commission and DNV; and

(M) Copy of the hospital's policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices.

(c) Each hospital shall update the documents in the links posted pursuant to subsection (b) of this Code section on July 1 of each year or more frequently at its discretion. Noncurrent documents shall remain posted and accessible on the hospital's website indefinitely.
(d) All documents listed in subsection (b) of this Code section shall be prepared in accordance with generally accepted accounting principles, as applicable.

(e) The department shall also post a link in a prominent location on its website to the documents listed in subsection (b) of this Code section for each hospital in this state.

(f) Any hospital that fails to post the documents required pursuant to subsection (b) of this Code section within 30 days of the dates required in this Code section shall be suspended from receiving any state funds or any donations pursuant to Code Section 48-7-29.20.

(g) The department shall have jurisdiction to enforce this Code section and to promulgate rules and regulations required to administer this Code section.

(h) Any person who knowingly and willfully includes false, fictitious, or fraudulent information in any documents required to be posted pursuant to this Code section shall be subject to a violation of Code Section 16-10-20.

31-7-23.

(a) As used in this Code section, the term:

(1) 'Hospital' shall have the same meaning as in Code Section 31-7-22.

(2) 'Medical use rights' means rights or interests in real property in which the owner of the property has agreed not to sell or lease such real property for identified medical uses or purposes.

(b) It shall be unlawful for any hospital to purchase, renew, extend, lease, maintain, or hold medical use rights.

(c) This Code section shall not be construed to impair any contracts in existence as of the effective date of this Code section. Reserved.

SECTION 2-2.

Said title is further amended by revising Code Section 31-7-75.1, relating to proceeds of sale of hospital held in trust to fund indigent hospital care, as follows:

"31-7-75.1. (a) The proceeds from any sale or lease of a hospital owned by a hospital authority or political subdivision of this state, which proceeds shall not include funds required to pay off the bonded indebtedness of the sold hospital or any expense of the authority or political subdivision attributable to the sale or lease, shall be held by the authority or political subdivision in an irrevocable trust fund. Such proceeds in that fund may be invested in the same way that public moneys may be invested generally pursuant to general law and as permitted under Code Section 31-7-83, but money in that trust fund shall be used exclusively for funding the provision of hospital health care for the indigent residents of the political subdivision which owned the hospital or by which the authority was activated.
or for which the authority was created. If the funds available for a political subdivision in
that irrevocable trust fund are less than $100,000.00, the principal amount may be used to
fund the provision of indigent hospital health care; otherwise, only the income from that
fund may be used for that care. Such funding or reimbursement for indigent care shall not
exceed the diagnosis related group rate for that hospital in each individual case.

(b) In the event a hospital authority which sold or leased a hospital was activated by or
created for more than one political subdivision or in the event a hospital having as owner
more than one political subdivision is sold or leased by those political subdivisions, each
such constituent political subdivision's portion of the irrevocable trust fund for indigent
hospital health care shall be determined by multiplying the amount of that fund by a figure
having a numerator which is the population of that political subdivision and a denominator
which is the combined population of all the political subdivisions which owned the hospital
or by which or for which the authority was activated or created.

(c) For purposes of hospital health care for the indigent under this Code section, the
standard of indigency shall be that determined under Code Section 31-8-43, relating to
standards of indigency for emergency care of pregnant women, based upon 125 percent of
the federal poverty level.

(d) This Code section shall not apply to the following actions:

(1) A reorganization or restructuring;

(2) Any sale of a hospital, or the proceeds from that sale, made prior to April 2, 1986;

(3) Any sale or lease of a hospital when the purchaser or lessee pledges, by written
contract entered into concurrently with such purchase or lease, to provide an amount of
hospital health care equal to that which would have otherwise been available pursuant to
subsections (a), (b), and (c) of this Code section for the indigent residents of the political
subdivisions which owned the hospital, by which the hospital authority was activated, or
for which the authority was created. However, the exception to this Code section
provided by this paragraph shall only apply to:

(A) Hospital authorities that operate a licensed hospital pursuant to a lease from the
county which created the appropriate authority; and

(B) Hospitals that have a bed capacity of more than 150 beds; and

(C) Hospitals located in a county in which no other medical-surgical licensed hospital
is located; and

(D) Hospitals located in a county having a population of less than 45,000 according to
the United States decennial census of 1990; and

(E) Hospitals operated by a hospital authority that entered into a lease-purchase
agreement between such hospital and a private corporation prior to July 1, 1997."

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SECTION 2-3.
Said title is further amended by adding a new Code section to Article 4 of Chapter 7, relating to hospital authorities, to read as follows:

"31-7-74.4. Members on the board of a hospital authority at the time of a sale or lease of a hospital owned by such hospital authority shall be deemed directors and subject to the provisions of Part 6 of Article 8 of Chapter 3 of Title 14, relating to conflicting interest transactions with respect to the proceeds of such sale or lease."

SECTION 2-4.
Said title is further amended by revising Code Section 31-7-83, relating to investment of surplus moneys and moneys received through issuance of revenue certificates, as follows:

"31-7-83. (a) Pending use for the purpose for which received, each hospital authority created by and under this article is authorized and empowered to invest all moneys or any part thereof received through the issuance and sale of revenue certificates of the authority in any securities which are legal investments or which are provided for in the trust indenture securing such certificates or other legal investments; provided, however, that such investments shall be used at all times while held, or upon sale, for the purposes for which the money was originally received and no other. Contributions or gifts received by any authority shall be invested as provided by the terms of the contribution or gift or in the absence thereof as determined by the authority.

(b) In addition to the authorized investments in subsection (a) of this Code section and in Code Section 36-83-4, hospital authorities that have ceased to own or operate medical facilities for a minimum of seven years, have paid off all bonded indebtedness and outstanding short-term or long-term debt obligations, and hold more than $20 million in funds for charitable health care purposes may invest a maximum of 30 percent of their funds in the following:

(1) Shares of mutual funds registered with the Securities and Exchange Commission of the United States under the 'Investment Company Act of 1940,' as amended; and

(2) Commingled funds and collective investment funds maintained by state chartered banks or trust companies or regulated by the Office of the Comptroller of the Currency of the United States Department of the Treasury, including common and group trusts, and, to the extent the funds are invested in such collective investment funds, the funds shall adopt the terms of the instruments establishing any group trust in accordance with applicable United States Internal Revenue Service Revenue Rulings."
SECTION 2-5.

Code Section 50-18-70 of the Official Code of Georgia Annotated, relating to legislative intent and definitions relative to open records laws, is amended by revising subsection (b) as follows:

"(b) As used in this article, the term:

(1) 'Agency' shall have the same meaning as in Code Section 50-14-1 and shall additionally include any association, corporation, or other similar organization that has a membership or ownership body composed primarily of counties, municipal corporations, or school districts of this state, their officers, or any combination thereof and derives more than 33 1/3 percent of its general operating budget from payments from such political subdivisions. Such term shall also include any nonprofit organization to which is leased and transferred hospital assets of a hospital authority through a corporate restructuring and any subsidiaries or foundations established by such nonprofit organization in furtherance of the public mission of the hospital authority.

(2) 'Public record' means all documents, papers, letters, maps, books, tapes, photographs, computer based or generated information, data, data fields, or similar material prepared and maintained or received by an agency or by a private person or entity in the performance of a service or function for or on behalf of an agency or when such documents have been transferred to a private person or entity by an agency for storage or future governmental use, including, but not limited to any such material in the possession or control of a nonprofit organization to which is leased and transferred hospital assets of a hospital authority through a corporate restructuring which are related to the operation of the hospital and other leased facilities in the performance of services on behalf of the hospital authority."

PART III

SECTION 3-1.

Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to care and protection of indigent and elderly patients, is amended by revising Code Section 31-8-9.1, relating to eligibility to receive tax credits and obligations of rural hospitals after receipt of funds, as follows:

"31-8-9.1. (a) As used in this Code section, the term:

(1) 'Critical access hospital' means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital
and that is recognized by the department as a critical access hospital for purposes of
Medicaid.
(2) 'Rural county' means a county having a population of less than 50,000 according to
the United States decennial census of 2010 or any future such census; provided, however,
that for counties which contain a military base or installation, the military personnel and
their dependents living in such county shall be excluded from the total population of such
county for purposes of this definition.
(3) 'Rural hospital organization' means an acute care hospital licensed by the department
pursuant to Article 1 of Chapter 7 of this title that:
(A) Provides inpatient hospital services at a facility located in a rural county or is a
critical access hospital;
(B) Participates in both Medicaid and medicare Medicare and accepts both Medicaid
and medicare Medicare patients;
(C) Provides health care services to indigent patients;
(D) Has at least 10 percent of its annual net revenue categorized as indigent care,
charity care, or bad debt;
(E) Annually files IRS Form 990, Return of Organization Exempt From Income Tax,
with the department, or for any hospital not required to file IRS Form 990, the
department will provide a form that collects the same information to be submitted to the
department on an annual basis;
(F) Is operated by a county or municipal authority pursuant to Article 4 of Chapter 7
of this title or is designated as a tax-exempt organization under Section 501(c)(3) of the
Internal Revenue Code; and
(G) Is current with all audits and reports required by law; and
(H) Does not have a margin above expenses of greater than 15 percent, as calculated
by the department.
(b)(1) By December 1 of each year, the department shall approve a list of rural hospital
organizations eligible to receive contributions from the tax credit provided pursuant to
Code Section 48-7-29.20 ranked in order of financial need and transmit such list to the
Department of Revenue.
(2) Before any rural hospital organization is included on the list as eligible to receive
contributions from the tax credit provided pursuant to Code Section 48-7-29.20, it shall
submit to the department a five-year plan detailing the financial viability and stability of
the rural hospital organization. The criteria to be included in the five-year plan shall be
established by the department.
(3) The department shall create an operations manual for identifying rural hospital organizations and ranking such rural hospital organizations in order of financial need. Such manual shall include:

(A) All deadlines for submitting required information to the department;

(B) The criteria to be included in the five-year plan submitted pursuant to paragraph (2) of this subsection; and

(C) The formula applied to rank the rural hospital organizations in order of financial need.

(c)(1) A rural hospital organization that receives donations pursuant to Code Section 48-7-29.20 shall:

(A) Utilize such donations for the provision of health care related services for residents of a rural county or for residents of the area served by a critical access hospital; and

(B) Report on a form provided by the department:

(i) All contributions received from individual and corporate donors pursuant to Code Section 48-7-29.20 detailing the manner in which the contributions received were expended by the rural hospital organization; and

(ii) Any payments made to a third party to solicit, administer, or manage the donations received by the rural hospital organization pursuant to this Code section or Code Section 48-7-29.20. In no event shall payments made to a third party to solicit, administer, or manage the donations received pursuant to this Code section exceed 3 percent of the total amount of the donations.

(2) The department shall annually prepare a report compiling the information received pursuant to paragraph (1) of this subsection for the chairpersons of the House Committee on Ways and Means and the Senate Health and Human Services Committee.

(d) The department shall post the following information in a prominent location on its website:

(1) The ranked list of rural hospital organizations eligible to receive contributions established pursuant to paragraph (1) of subsection (b) of this Code section;

(2) The operations manual created pursuant to paragraph (3) of subsection (b) of this Code section;

(3) The annual report prepared pursuant to paragraph (2) of subsection (c) of this Code section;

(4) The total amount received by each third party that participated in soliciting, administering, or managing donations; and

(5) A link to the Department of Revenue's website containing the information included in subsection (d) of Code Section 48-7-29.20.
SECTION 3-2.

Code Section 48-7-29.20 of the Official Code of Georgia Annotated, relating to tax credits for contributions to rural hospital organizations, is amended as follows:

"48-7-29.20.

(a) As used in this Code section, the term:

(1) 'Qualified rural hospital organization expense' means the contribution of funds by an individual or corporate taxpayer to a rural hospital organization for the direct benefit of such organization during the tax year for which a credit under this Code section is claimed.

(2) 'Rural hospital organization' means an organization that is approved by the Department of Community Health pursuant to Code Section 31-8-9.1.

(b) An individual taxpayer shall be allowed a credit against the tax imposed by this chapter for qualified rural hospital organization expenses as follows:

(1) In the case of a single individual or a head of household, the actual amount expended;

(2) In the case of a married couple filing a joint return, the actual amount expended; or

(3) In the case of an individual who is a member of a limited liability company duly formed under state law, a shareholder of a Subchapter 'S' corporation, or a partner in a partnership, the amount expended; provided, however, that tax credits pursuant to this paragraph shall be allowed only for the portion of the income on which such tax was actually paid by such individual.

(b.1) From January 1 to June 30 each taxable year, an individual taxpayer shall be limited in its qualified rural hospital organization expenses allowable for credit under this Code section, and the commissioner shall not approve qualified rural hospital organization expenses incurred from January 1 to June 30 each taxable year, which exceed the following limits:

(1) In the case of a single individual or a head of household, $5,000.00;

(2) In the case of a married couple filing a joint return, $10,000.00; or

(3) In the case of an individual who is a member of a limited liability company duly formed under state law, a shareholder of a Subchapter 'S' corporation, or a partner in a partnership, $10,000.00.

(c) A corporation or other entity shall be allowed a credit against the tax imposed by this chapter for qualified rural hospital organization expenses in an amount not to exceed the actual amount expended or 75 percent of the corporation's income tax liability, whichever is less.

(d) In no event shall the total amount of the tax credit under this Code section for a taxable year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the
taxpayer against the succeeding five years' tax liability. No such credit shall be allowed
the taxpayer against prior years' tax liability.

(e)(1) In no event shall the aggregate amount of tax credits allowed under this Code
section exceed $60 million per taxable year.

(2)(A) No more than $4 million of the aggregate limit established by paragraph (1) of
this subsection shall be contributed to any individual rural hospital organization in any
taxable year. From January 1 to June 30 each taxable year, the commissioner shall only
preapprove contributions submitted by individual taxpayers in an amount not to exceed
$2 million, and from corporate donors in an amount not to exceed $2 million. From
July 1 to December 31 each taxable year, subject to the aggregate limit in paragraph (1)
of this subsection and the individual rural hospital organization limit in this paragraph,
the commissioner shall approve contributions submitted by individual taxpayers and
corporations or other entities.

(B) In the event an individual or corporate donor desires to make a contribution to an
individual rural hospital organization that has received the maximum amount of
contributions for that taxable year, the Department of Community Health shall provide
the individual or corporate donor with a list, ranked in order of financial need, as
determined by the Department of Community Health, of rural hospital organizations
still eligible to receive contributions for the taxable year.

(C) In the event that an individual or corporate donor desires to make a contribution
to an unspecified or undesignated rural hospital organization, either directly to the
department or through a third party that participates in soliciting, administering, or
managing donations, such donation shall be attributed to the rural hospital organization
ranked with the highest financial need that has not yet received the maximum amount
of contributions for that taxable year, regardless of whether a third party has a
contractual relationship or agreement with such rural hospital organization.

(D) Any third party that participates in soliciting, advertising, or managing donations
shall provide the complete list of rural hospital organizations eligible to receive the tax
credit provided pursuant to this Code section including their ranking in order of
financial need as determined by the Department of Community Health pursuant to Code
Section 31-8-9.1, to any potential donor regardless of whether a third party has a
contractual relationship or agreement with such rural hospital organization.

(3) For purposes of paragraphs (1) and (2) of this subsection, a rural hospital
organization shall notify a potential donor of the requirements of this Code section.
Before making a contribution to a rural hospital organization, the taxpayer shall
electronically notify the department, in a manner specified by the department, of the total
amount of contribution that the taxpayer intends to make to the rural hospital
organization. The commissioner shall preapprove or deny the requested amount within 30 days after receiving the request from the taxpayer and shall provide written notice to the taxpayer and rural hospital organization of such preapproval or denial which shall not require any signed release or notarized approval by the taxpayer. In order to receive a tax credit under this Code section, the taxpayer shall make the contribution to the rural hospital organization within 60 days after receiving notice from the department that the requested amount was preapproved. If the taxpayer does not comply with this paragraph, the commissioner shall not include this preapproved contribution amount when calculating the limits prescribed in paragraphs (1) and (2) of this subsection.

(4)(A) Preapproval of contributions by the commissioner shall be based solely on the availability of tax credits subject to the aggregate total limit established under paragraph (1) of this subsection and the individual rural hospital organization limit established under paragraph (2) of this subsection.

(B) Any taxpayer preapproved by the department pursuant to this subsection (e) of this Code section shall retain their approval in the event the credit percentage in subsection (b) of this Code section is modified for the year in which the taxpayer was preapproved.

(C) Upon the rural hospital organization’s confirmation of receipt of donations that have been preapproved by the department, any taxpayer preapproved by the department pursuant to subsection (c) of this Code section shall receive the full benefit of the income tax credit established by this Code section even though the rural hospital organization to which the taxpayer made a donation does not properly comply with the reports or filings required by this Code section.

(5) Notwithstanding any laws to the contrary, the department shall not take any adverse action against donors to rural hospital organizations if the commissioner preapproved a donation for a tax credit prior to the date the rural hospital organization is removed from the Department of Community Health list pursuant to Code Section 31-8-9.1, and all such donations shall remain as preapproved tax credits subject only to the donor’s compliance with paragraph (3) of this subsection.

(f) In order for the taxpayer to claim the tax credit under this Code section, a letter of confirmation of donation issued by the rural hospital organization to which the contribution was made shall be attached to the taxpayer's tax return. However, in the event the taxpayer files an electronic return, such confirmation shall only be required to be electronically attached to the return if the Internal Revenue Service allows such attachments when the return is transmitted to the department. In the event the taxpayer files an electronic return and such confirmation is not attached because the Internal Revenue Service does not, at the time of such electronic filing, allow electronic attachments to the Georgia return, such confirmation shall be maintained by the taxpayer and made available upon request by the department.
commissioner. The letter of confirmation of donation shall contain the taxpayer's name, address, tax identification number, the amount of the contribution, the date of the contribution, and the amount of the credit.

(g) No credit shall be allowed under this Code section with respect to any amount deducted from taxable net income by the taxpayer as a charitable contribution to a bona fide charitable organization qualified under Section 501(c)(3) of the Internal Revenue Code.

(h) The commissioner shall be authorized to promulgate any rules and regulations necessary to implement and administer the provisions of this Code section.

(i) The department shall post the following information in a prominent location on its website:

1. All pertinent timelines relating to the tax credit, including, but not limited to:
   A. Beginning date when contributions can be submitted for preapproval by donors for the January 1 to June 30 period;
   B. Ending date when contributions can be submitted for preapproval by donors for the January 1 to June 30 period;
   C. Beginning date when contributions can be submitted for preapproval by donors for the July 1 to December 31 period;
   D. Ending date when contributions can be submitted for preapproval by donors for the July 1 to December 31 period; and
   E. Date by which preapproved contributions are required to be sent to the rural hospital organization;

2. The list and ranking order of rural hospital organizations eligible to receive contributions established pursuant to paragraph (1) of subsection (b) of Code Section 31-8-9.1;

3. A monthly progress report including:
   A. Total preapproved contributions to date by rural hospital organization;
   B. Total contributions received to date by rural hospital organization;
   C. Total aggregate amount of preapproved contributions made to date; and
   D. Aggregate amount of tax credits available;

4. A list of all preapproved contributions that were made to an unspecified or undesignated rural hospital organization and the rural hospital organizations that received such contributions.

(j) The Department of Audits and Accounts shall annually conduct an audit of the tax credit program established under this Code section, including the amount and recipient rural hospital organization of all contributions made, all tax credits received by individual
and corporate donors, and all amounts received by third parties that solicited, administered,
or managed donations pertaining to this Code section and Code Section 31-8-9.1.

(k) This Code section shall stand automatically repealed on December 31, 2024.

PART IV

SECTION 4-1.

This Act shall become effective upon its approval by the Governor or upon its becoming law
without such approval.

SECTION 4.2.

All laws and parts of laws in conflict with this Act are repealed.