



State of Illinois
Illinois Department of Healthcare and Family Services

LONG TERM CARE (SNF/ICF) PROVIDER MONTHLY ASSESSMENT REPORT

Example

HFS Assessment Tax ID: 6010101 (7 digit number beginning with 6)

Facility Name: Hometown Provider

Address: 46 Meadow Lane

City: Hometown State: IL Zip: 62626

Initial report: Corrected report:

Reporting Period: April 1, 20XX to April 30, 20XX Payment Due Date: July X, 20XX

**The table below is the census for the entire reporting period.
Provide occupied bed days by level of care and primary payment sources.**

	1	2	3	4	5
	Level of Care	Medicaid	Medicare	Other	Total
1	SNF	400	600	300	1,300
2	SNF/PED	200	0	100	300
3	ICF	0	0	0	0
4	ICF/DD	0	0	0	0
5	TOTAL	600	600	400	1,600

Assessment Calculation

6	Number of Occupied Beds (Line 5 column 5)	1,600
7	Minus Number of Medicare Occupied Beds (Line 5 Column 3)	600
8	Net Occupied Beds (Line 6 Minus Line 7)	1000
9	Assessment Per Occupied Bed	\$6.07
10	Assessment Amount Due (Multiply Line 8 by line 9 and round to the nearest dollar)	\$6,070

MAKE CHECK PAYABLE TO: HEALTHCARE AND FAMILY SERVICES

Please remit to: HFS/Bureau of Fiscal Operations

P.O. Box 19491

Springfield, Illinois 62794-9491

PAYMENT IS ENCLOSED: YES NO CHECK NUMBER 9999

I have examined the contents of the accompanying report for the period 04 / 01 / 2011 through 04 / 30 / 2011 to the State of Illinois, and certify that, to the best of my knowledge and belief, the said contents are true, accurate and complete statements in accordance with applicable instructions. Intentional misrepresentation or falsification of any information on this report may be punishable by fine and/or imprisonment.

PROVIDER OFFICER OR ADMINISTRATOR SIGNATURE

Signature _____

Print Name _____

Title _____ Date _____



State of Illinois
 Illinois Department of Healthcare and Family Services

LONG TERM CARE (SNF/ICF) PROVIDER MONTHLY ASSESSMENT REPORT

HFS Assessment Tax ID: «TaxID» (7 digit number beginning with 6)

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Initial report: Corrected report:

Reporting Period: _____ to _____ Payment Due Date: September 3, 2012

The table below is the census for the entire reporting period. Provide occupied bed days by level of care and primary payment sources.					
	1	2	3	4	5
	Level of Care	Medicaid	Medicare	Other	Total
1	SNF				
2	SNF/PED				
3	ICF				
4	ICF/DD				
5	TOTAL				

Assessment Calculation

6	Number of Occupied Beds (Line 5 column 5)	
7	Minus Number of Medicare Occupied Beds (Line 5 Column 3)	
8	Net Occupied Beds (Line 6 Minus Line 7)	
9	Assessment Per Occupied Bed	\$6.07
10	Assessment Amount Due (Multiply Line 8 by line 9 and round to the nearest dollar)	

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PROVIDER OFFICER OR ADMINISTRATOR SIGNATURE

Signature _____

Print Name _____

Title _____ Date _____

Illinois Department of Healthcare and Family Services

Fiscal Year 2013 LTC Occupied Bed Provider Assessment (Fund 345) Chart of Important Dates

LTC Tax Report Reporting Period	Assessment Period	Provider Assessment Report and Payment Due Date
October 1 - 31 2011	January-2012	September 3, 2012
November 1 - 30 2011	February-2012	September 3, 2012
December 1 - 31 2011	March-2012	September 3, 2012
January 1 - 31 2012	April-2012	September 3, 2012
February 1 - 29 2012	May-2012	September 3, 2012
March 1 - 31 2012	June-2012	September 3, 2012
April 1 - 30 2012	July-2012	TBD
May 1 - 31 2012	August-2012	TBD
June 1 - 30 2012	September-2012	TBD
July 1 - 31 2012	October-2012	TBD
August 1 - 31 2012	November-2012	TBD
September 1 - 30 2012	December-2012	TBD
October 1 - 31 2012	January-2013	TBD
November 1 - 30 2012	February-2013	TBD
December 1 - 31 2012	March-2013	TBD
January 1 - 31 2013	April-2013	TBD
February 1 - 29 2013	May-2013	TBD
March 1 - 31 2013	June-2013	TBD